

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02064

2099

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Tuxedo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Tuxedo</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2303-57th Ave.</u>		STREET ADDRESS <u>2303-57th Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mary Edith Alder</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 23, 1957</u>	
5. SEX <u>F</u>	6. COLOR OF RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar. 9, 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE last birthday <u>86</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Jos. H. Wood</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Beans</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Mrs. William Scott, Grand daughter</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pneumonia Thromboly Embolism</u>		<u>Pneumonia</u>	<u>40 hrs</u>
Antecedent cause(s) (b) <u>493X</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb. 22, 1957 to Feb. 23, 1957, that I last saw the deceased alive on Feb. 22, 1957, and that death occurred at 3:46 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Robert R. Bailey MD 2409 Vernon St. Beltsville, Md. 2/23/57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Removal - Burial</u>	<u>Feb. 26/57</u>	<u>Lakeview Cemetery</u>	<u>Hamilton, Va.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>FEB 26 1957</u>	<u>W. Leach</u>	<u>J. Dascho Sons</u>	<u>Hyattsville, Md.</u>

Mary Charlotte Beans

Spokane
Idaho

Spokane
Idaho

BUREAU V. S.

FEB 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02066

2055 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 10Days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 5810 Allentown Rd..					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Frances America				4. DATE OF DEATH Month Day Year Feb. 18 19 57					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-7-1894			
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME Joseph Cushman				14. MOTHER'S MAIDEN NAME Rosa Kimble					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.					
17. INFORMANT Thelma Miller La Plata, Md Daughter									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RLL Infarction c pul. Centul. DUE TO (c) Myocardial Infarction								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from Feb 17, 19 57, to Feb 18, 19 57, that I last saw the deceased alive on Feb 18, 19 57, and that death occurred at 3:15 P. M. from the causes and on the date stated above.									
ACTUAL SIGNATURE William D. Rosson M.D.				ADDRESS (Street, city or town, state) 5304 Annapolis Rd Bladensburg, Maryland					
DATE SIGNED 2-19-57									
PHYSICIAN'S NAME (Type) William D. Rosson M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert D. Mattingly				ADDRESS 131-11-28 Wash, D.C.		24a. REC'D BY REGISTRAR DATE FEB 25 57			
24b. REGISTRAR'S SIGNATURE									

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. CITY OF BIRTH</p>	
<p>7. OCCUPATION</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. DATE OF DEATH</p>	
<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>	
<p>15. SIGNATURE OF CLERK</p>		<p>16. SIGNATURE OF REGISTRAR</p>	

BUREAU V. 2

FEB 25 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03193

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY 	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Crestwood	
3. NAME OF DECEASED (Type or print) First Carmiller Middle Austin Last 		4. DATE OF DEATH Month Feb. Day 27 Year 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August , 1906
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY S. Carolina	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jim Long		14. MOTHER'S MAIDEN NAME Tecora Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Wydell Austin, 233 7th St., N.E. Wash., D.C.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Drowning Conditions, if any, which gave rise to immediate cause (b) (c) Automobile accident (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in automobile which went over a bank throwing de -	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 4:30 p.m. 2-27 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. Colmar Manor, Pr. Geo. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 27, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/6/57		22b. DATE THEREOF 3/6/57	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Malvan & Schuy, Inc. 424-R St. N.W.		24a. REC'D BY REGISTRAR DATE Mar 1 1957	
24b. REGISTRAR'S SIGNATURE Ch. H. Smith			

MINNESOTA STATE DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Residence		Occupation		Cause of Death	
123 Main Street, St. Paul, Minn.		Teacher		Heart Disease	
Date of Death		Place of Death		Time of Death	
Feb. 15, 1957		Home		10:30 AM	
Medical History		Mental History		Autopsy	
Hypertension, Diabetes		None		Yes	
Previous Illnesses		Previous Operations		Previous Injuries	
None		None		None	
Signature of Examiner		Signature of Physician		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Date of Death		Date of Burial	
Feb. 16, 1957		Feb. 15, 1957		Feb. 17, 1957	

BUREAU V. 5

MAR 13 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02067

2057

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harmon			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge 13x02			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial				d. STREET ADDRESS Rt. 4, Box 272			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mildred Middle Hazel Last Barkley				4. DATE OF DEATH Month February Day 3 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-29-1909	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 10 Days 4	IF UNDER 24 HRS. Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Fred Wurth				14. MOTHER'S MAIDEN NAME Alice Snyder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 154X DUE TO Carcinoma of Rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH Long
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from Feb 26 , 19 57 , to February 3 , 19 57 , that I last saw the deceased alive on February 3 , 19 57 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Harmon, Md. DATE SIGNED February 3, 1957							
ACTUAL SIGNATURE Robert Wingfield M.D.							
PHYSICIAN'S NAME (Type) Robert Wingfield, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 7, 1957		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Syracuse, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler				ADDRESS 1756 Pader N.W.		24a. REC'D BY REGISTRAR DATE Feb 6 1957	
				24b. REGISTRAR'S SIGNATURE Ms. Jas. Severe			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2058

CERTIFICATE OF DEATH

02068

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4510 Sheridan St</u>		d. STREET ADDRESS <u>4510 Sheridan St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Luvenia</u> First Middle Last <u>Bogle</u>		4. DATE OF DEATH <u>Feb</u> Month <u>17</u> Day <u>1957</u> Year	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 14, 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James M. Pruett</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Fanning</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mary Bogle</u> Address <u>4510 Sheridan St Riverdale, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>9 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 17</u> , 19 <u>57</u> , to <u>Feb 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 17</u> , 19 <u>57</u> , and that death occurred at <u>1:43</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malin</u>		M.D. <u>Riverdale, Md.</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>2-17-57</u>	
PHYSICIAN'S NAME (Type) <u>L W. Malin</u>		<u>Riverdale, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>2/19/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wytheville</u>		22d. LOCATION (City, town, or county) (State) <u>Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland.</u>	
24a. REC'D BY REGISTRAR <u>Feb 19 1957</u>		DATE <u>James L. ...</u>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

RECEIVED
FEB 19 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 0211 2-25-57 et

CERTIFICATE OF DEATH

02069

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount Heights Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>701- Addison Rd</u>				d. STREET ADDRESS <u>701- Addison Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ELLEN</u> Middle <u>LEE</u> Last <u>BOLLING</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>		IF UNDER 24 HRS. Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Thoms</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>331X</u>		17. INFORMANT <u>MARY-A. BOLLING</u> Address <u>701- Addison Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO <u>331X</u> (c) <u>331X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4-14-22</u> , 1957, to <u>Feb-16</u> , 1957, that I last saw the deceased alive on <u>Feb-16</u> , 1957, and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Washington D.C.</u> DATE SIGNED <u>H. E. Belden</u>							
ACTUAL SIGNATURE <u>H. E. Belden</u> M.D. <u>44-23-HUNT-PLNE</u>							
PHYSICIAN'S NAME (Type) <u>H. E. Belden MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-20-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Washington Sons</u> ADDRESS <u>462 N St NE Wash DC</u>				24a. REC'D BY REGISTRAR <u>DATE 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. RACE		7. COLOR		8. SEX OF DECEASED		9. SEX OF DECEASED		10. SEX OF DECEASED		11. SEX OF DECEASED		12. SEX OF DECEASED		13. SEX OF DECEASED		14. SEX OF DECEASED		15. SEX OF DECEASED		16. SEX OF DECEASED		17. SEX OF DECEASED		18. SEX OF DECEASED		19. SEX OF DECEASED		20. SEX OF DECEASED		21. SEX OF DECEASED		22. SEX OF DECEASED		23. SEX OF DECEASED		24. SEX OF DECEASED		25. SEX OF DECEASED		26. SEX OF DECEASED		27. SEX OF DECEASED		28. SEX OF DECEASED		29. SEX OF DECEASED		30. SEX OF DECEASED		31. SEX OF DECEASED		32. SEX OF DECEASED		33. SEX OF DECEASED		34. SEX OF DECEASED		35. SEX OF DECEASED		36. SEX OF DECEASED		37. SEX OF DECEASED		38. SEX OF DECEASED		39. SEX OF DECEASED		40. SEX OF DECEASED		41. SEX OF DECEASED		42. SEX OF DECEASED		43. SEX OF DECEASED		44. SEX OF DECEASED		45. SEX OF DECEASED		46. SEX OF DECEASED		47. SEX OF DECEASED		48. SEX OF DECEASED		49. SEX OF DECEASED		50. SEX OF DECEASED		51. SEX OF DECEASED		52. SEX OF DECEASED		53. SEX OF DECEASED		54. SEX OF DECEASED		55. SEX OF DECEASED		56. SEX OF DECEASED		57. SEX OF DECEASED		58. SEX OF DECEASED		59. SEX OF DECEASED		60. SEX OF DECEASED		61. SEX OF DECEASED		62. SEX OF DECEASED		63. SEX OF DECEASED		64. SEX OF DECEASED		65. SEX OF DECEASED		66. SEX OF DECEASED		67. SEX OF DECEASED		68. SEX OF DECEASED		69. SEX OF DECEASED		70. SEX OF DECEASED		71. SEX OF DECEASED		72. SEX OF DECEASED		73. SEX OF DECEASED		74. SEX OF DECEASED		75. SEX OF DECEASED		76. SEX OF DECEASED		77. SEX OF DECEASED		78. SEX OF DECEASED		79. SEX OF DECEASED		80. SEX OF DECEASED		81. SEX OF DECEASED		82. SEX OF DECEASED		83. SEX OF DECEASED		84. SEX OF DECEASED		85. SEX OF DECEASED		86. SEX OF DECEASED		87. SEX OF DECEASED		88. SEX OF DECEASED		89. SEX OF DECEASED		90. SEX OF DECEASED		91. SEX OF DECEASED		92. SEX OF DECEASED		93. SEX OF DECEASED		94. SEX OF DECEASED		95. SEX OF DECEASED		96. SEX OF DECEASED		97. SEX OF DECEASED		98. SEX OF DECEASED		99. SEX OF DECEASED		100. SEX OF DECEASED	
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BUREAU V. 3

FEB 20 1957

RECEIVED

2053 CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier, Maryland.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3828 34th Street,.		d. STREET ADDRESS 3828 34th St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EDGAR HAMILTON BON DURANT		4. DATE OF DEATH Month February 9, Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 3, 1871
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U S Government	11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME George Bon Durant		14. MOTHER'S MAIDEN NAME Nancy Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs Lucy M Bon Durant Address Mt Rainier, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS (c) GENERALIZED ARTERIO SCLEROSIS			INTERVAL BETWEEN ONSET AND DEATH 36 HRS. 8 YRS 8 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1953 to FEB 9, 1957, that I last saw the deceased alive on FEB 8, 1957, and that death occurred at 6 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin S. Miller		ADDRESS (Street, city or town, state) 3824-34th Mt Rainier Md DATE SIGNED FEB 9 1957	
PHYSICIAN'S NAME (Type) BENJAMIN S. MILLER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/11/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	24a. REC'D BY REGISTRAR DATE 2-13-57
		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Seaver	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 1 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1957 1A 223

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 0211 3-5-57 et

02071

CERTIFICATE OF DEATH

2060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2. MUIRKIRK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.		d. STREET ADDRESS Rossville Road	
3. NAME OF DECEASED (Type or print) First G Middle EORGE Last BRIGGS		4. DATE OF DEATH Month FEB. Day 22 Year 1957	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-79
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Briggs		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Rt. Hydrothorax 493x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopleural Fistula DUE TO (c) Unresolved Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 1 week 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-19 , 19 57 to 2-22 , 19 57 , that I last saw the deceased alive on 2-22 , 19 57 , and that death occurred at 11:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon W. Kelley		ADDRESS (Street, city or town, state) 6124-41st Ave. Hyattsville, Md.	
PHYSICIAN'S NAME (Type) Gordon W. Kelley		DATE SIGNED 2-22-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/57	
22c. NAME OF CEMETERY OR CREMATORY Queens Chapel		22d. LOCATION (City, town, or county) (State) Muirkirk Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		ADDRESS 467 N. St. N.W.	
24a. REC'D BY REGISTRAR Feb 28 57		24b. REGISTRAR'S SIGNATURE W. H. Smith	

BUREAU V. 5

RECEIVED

2061

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 17 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sam Middle Brooks Last Brooks		4. DATE OF DEATH Month Feb Day 12 Year 19 57	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 79 ? yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Capable to work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Anne Arundel		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Joseph Watkins Laurel Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident DUE TO (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dysphagia of toes secondary to Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 6:25 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE D. S. Clayman		ADDRESS (Street, city or town, state) 6311 Belts Ave. Riverdale Md	
PHYSICIAN'S NAME (Type) M.D.		DATE SIGNED 3/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 17/1957	
22c. NAME OF CEMETERY OR CREMATORY Becons Chapel		22d. LOCATION (City, town, or county) (State) Anne Arundel Md	
23. FUNERAL DIRECTOR'S SIGNATURE R. D. S. Clayman		24a. REC'D BY REGISTRAR DATE FEB 19 57	
ADDRESS 401 N. Main Ave. Prince George		24b. REGISTRAR'S SIGNATURE A. K. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH _____		MARRIAGE _____	
DATE OF DEATH _____		SEX OF DECEASED _____	
TIME OF DEATH _____		AGE OF DECEASED _____	
PLACE OF BIRTH _____		OCCUPATION _____	
DATE OF BIRTH _____		COLOR OF SKIN _____	
TIME OF BIRTH _____		HEIGHT _____	
PLACE OF BIRTH _____		WEIGHT _____	
DATE OF BIRTH _____		TEMPERATURE _____	
TIME OF BIRTH _____		PULSE _____	
PLACE OF BIRTH _____		RESPIRATION _____	
DATE OF BIRTH _____		BLOOD PRESSURE _____	
TIME OF BIRTH _____		URINE _____	
PLACE OF BIRTH _____		STOOL _____	
DATE OF BIRTH _____		OTHER _____	
TIME OF BIRTH _____		SIGNATURE _____	
PLACE OF BIRTH _____		ADDRESS _____	
DATE OF BIRTH _____		CITY _____	
TIME OF BIRTH _____		STATE _____	
PLACE OF BIRTH _____		COUNTRY _____	

BUREAU V. S.

FEB 19 1957

RECEIVED

02073

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park,		c. LENGTH OF STAY IN 1b 7yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) 8800 36th Ave.		d. STREET ADDRESS 8800 36th Ave.					
3. NAME OF DECEASED (Type or print) Johanna		First Middle Last Bryant		4. DATE OF DEATH February 11, 19 57		Month Day Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 10, 1896	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Decator Quade		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Amos S. Bryant - 8800 36th Ave. Col. Pk. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive, cardio-vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1953, to Feb. 1957, that I last saw the deceased alive on Feb. 1, 1957, and that death occurred at 9:00A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE M.D.							
PHYSICIAN'S NAME (Type) Wolcott L. Etienne, M.D.		4713 Berwyn Road, College Park, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/57		22c. NAME OF CEMETERY OR CREMATORY St Johns Cemetery		22d. LOCATION (City, town, or county) (State) Beltsville, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.		ADDRESS		24a. REC'D BY REGISTRAR DATE 2/14/57		24b. REGISTRAR'S SIGNATURE John R. Smith	

Dr. John T. Maloney, Deputy Medical Examiner
Notified and O.K.'d.

W. E. [Signature]

RECEIVED

FEB 14 1957

BUREAU V. S.

2062

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3101 63RD AVE		d. STREET ADDRESS 3101 63rd avenue,.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FERDINAND Middle CARDANO Last CARDANO		4. DATE OF DEATH Month February Day 20 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 5, 1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Government		10b. KIND OF BUSINESS OR INDUSTRY Electrical Eng.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Conrad Cardano		14. MOTHER'S MAIDEN NAME Theresa	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. none	
17. INFORMANT Candita Cardano Address Cheverly, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE Arteriosclerotic Cardiovascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) VIRUS PNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1, 1957 , to Feb 20, 1957 , that I last saw the deceased alive on Feb 20, 1957 , and that death occurred at 5 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Rosson MD		ADDRESS (Street, city or town, state) 5304 Annapolis Rd, Bladensburg Maryland	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/25/57	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE F. Paschi son Kyatherle Inf		ADDRESS _____	
24a. REC'D BY REGISTRAR FEB 27 '57		24b. REGISTRAR'S SIGNATURE W. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

FB 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the coroner. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) E. Riverdale	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS 5412 55th Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Josephine Veronica Carter		4. DATE OF DEATH Month Day Year February 28, 19 57	
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 27, 1923
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Truman Hilliary Thomas		14. MOTHER'S MAIDEN NAME Mary Emily Carter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James Victor Carter; same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured ectopic pregnancy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 28, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-5-57	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	22d. LOCATION (City, town, or county) (State) FT. MYER, VIRG-IN-14
23. FUNERAL DIRECTOR'S SIGNATURE Alex S. Pope		ADDRESS 414-15th St, S.E.	
24a. REC'D BY REGISTRAR DATE MAR 1 57		24b. REGISTRAR'S SIGNATURE Qu. Smith	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Date of Death

Place of Death

Name of Deceased

Age of Deceased

Date of Birth

Place of Birth

Gender

Occupation

Cause of Death

Date of Death

Place of Death

Name of Deceased

Age of Deceased

Date of Birth

Place of Birth

Name of Deceased

Name of Deceased

Name of Deceased

BUREAU V. 2

MAR 1 1957

RECEIVED

2064
CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>William</u> Last <u>Confer Sr.</u>				4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 21, 1906</u>	
9. AGE (In years last birthday) <u>50 51</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ass. Supt. Agr. Research Center - Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Alvie Confer</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Ellen Long</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edna Confer</u> Address <u>Beltsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks undetermined</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) _____ (County) _____ (State) _____			21. I certify that I attended the deceased from <u>Feb 12, 1957</u> , to <u>Feb 26, 1957</u> , that I last saw the deceased alive on <u>Feb 26, 1957</u> , and that death occurred at <u>10:45</u> M., from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				DATE SIGNED <u>2-26-57</u>			
PHYSICIAN'S NAME (Type) <u>L. W. Malin, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Mill Hall</u> (State) <u>Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland.</u>				24a. REC'D BY REGISTRAR <u>MAR 5 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>James Severs</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

MAR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

020773

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Mitchellville		c. LENGTH OF STAY IN 1b 6 Mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Queen Anne Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Seat Pleasant	
3. NAME OF DECEASED (Type or print) First Mary Middle Margaret Last Cooke		4. DATE OF DEATH Month February Day 23, Year 19 57.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1866
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 91 Days 91 Hours 91 Min. 91	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Tenant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Robert Norfolk		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Ruth Tippet -- Mitchellville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour --- a. m. --- p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James I. Boyd</i>		DATE SIGNED 2/23/57.	
EXAMINER'S NAME (Type) James I. Boyd, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/57.	
22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) (State) Forestville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR FEB 28 1957	
24b. REGISTRAR'S SIGNATURE <i>Agnes Young</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FEB 28 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

243

2191

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Md				c. LENGTH OF STAY IN 1b 34 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Nora Elizabeth Cowan				4. DATE OF DEATH Month Day Year Feb 16 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1895		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eugene H. Shegogue				14. MOTHER'S MAIDEN NAME Susan Chaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT John J. Cowan Sr Bowie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193X DUE TO gleic blastoma multiforme of the brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 1956 to Feb 16 1957, that I last saw the deceased alive on Feb 14 1957, and that death occurred at 10:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. James Kurtz M.D.				ADDRESS (Street, city or town, state) P.O. Box 1000 Bowie, Md.			
PHYSICIAN'S NAME (Type) H. James Kurtz				DATE SIGNED 2/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/57		22c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Collington Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR FEB 19 1957		24b. REGISTRAR'S SIGNATURE Agnes Youngling	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]		RACE [Handwritten: White]	
DATE OF BIRTH [Handwritten: 1/15/1900]		PLACE OF BIRTH [Handwritten: New York City, N.Y.]		STATE OF BIRTH [Handwritten: New York]	
DATE OF DEATH [Handwritten: 2/10/1957]		PLACE OF DEATH [Handwritten: New York City, N.Y.]		STATE OF DEATH [Handwritten: New York]	
TIME OF DEATH [Handwritten: 10:15 A.M.]		CAUSE OF DEATH [Handwritten: Heart Disease]		MANNER OF DEATH [Handwritten: Natural]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF NEXT OF KIN [Handwritten: Jane Doe]		SIGNATURE OF PHYSICIAN [Handwritten: Dr. J. Smith]	
SIGNATURE OF REGISTRAR [Blank]		SIGNATURE OF CLERK [Blank]		SIGNATURE OF JUDGE [Blank]	

RECEIVED
 FEB 19 1957
 BUREAU V. S.

2102

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>3000 Surrey Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Archie</u> Middle <u>D</u> Last <u>Cox</u>				4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-10-1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Cox</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>James S Cox</u> Address <u>3503 Longfellow St Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive and Atherosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8 months</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 2</u> , 19 <u>56</u> , to <u>Feb 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 7</u> , 19 <u>57</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Brennan</u> M.D.				ADDRESS (Street, city or town, state) <u>3425 12th St, N.E.</u>			
PHYSICIAN'S NAME (Type) <u>John F. Brennan</u>				DATE SIGNED <u>2/8/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-11-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>	
22d. LOCATION (City, town, or county) (State) <u>Pr George Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Mattingly</u> ADDRESS <u>131-11th St SE</u>				24a. REC'D BY REGISTRAR <u>Feb 11 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

FILE NO.

31-0

DECEASED



BUREAU V. 2

FEB 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2103

CERTIFICATE OF DEATH

Reg. Dist. No.

02080
234

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs				c. LENGTH OF STAY IN 1b 2 Yrs - 2 Mo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1401st USAF Hospital, MATS				e. STREET ADDRESS Louisiana Avenue			
3. NAME OF DECEASED (Type or print) First Ralph Middle Hamrick Last Davis				4. DATE OF DEATH Month February Day 21 Year 1957			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 April 1912	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Otis Davis				14. MOTHER'S MAIDEN NAME Millie Mae Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1940 - 1957		17. INFORMANT USAF Military Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH hrs yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 21 February 1957 , to 21 February 1957 , that I last saw the deceased alive on 21 February , 1957, and that death occurred at 2018P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Richard C. Scibetta M.D. Andrews AFB, Washington 25, D.C. 21 Feb 57 PHYSICIAN'S NAME (Type) RICHARD C. SCIBETTA Andrews AFB, Washington 25, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-57	22c. NAME OF CEMETERY OR CREMATORY West View Cemetery		22d. LOCATION (City, town, or county) (State) Douglasville Georgia		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517-11th St. S.E.			24a. REC'D BY REGISTRAR DATE FEB 25 1957		24b. REGISTRAR'S SIGNATURE Carrie Campbell		

MEDICAL CERTIFICATION

2

50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1270

2010

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

Join Us in Davis

7202 - 0102 - 030

BUREAU V. S.

FEB 25 1957

RECEIVED

2104

CERTIFICATE OF DEATH

02081

Reg. Dist. No.

734

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b 3 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5630 ALLENTOWN RD.				d. STREET ADDRESS 15630 ALLENTOWN RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANDREW Middle L. Last DAY				4. DATE OF DEATH Month FEB Day 23 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH NOV 8 - 1888		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Gravel Co		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph J. Day				14. MOTHER'S MAIDEN NAME Grace E. Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-18-2138		17. INFORMANT Elsie G. Foreless Address Rt #2 Botolph			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE WITH SEVERE ANGINA PECTORIS DUE TO (c) 6 mos. +						INTERVAL BETWEEN ONSET AND DEATH 1 HR.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour a.m. NONE p.m. 19		20d. INJURY OCCURRED While at work NONE Not at work NONE		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) NONE		20f. (City or town) (County) (State) NONE	
21. I certify that I attended the deceased from NOV. 1956 to FEB 22, 1957 that I last saw the deceased alive on FEB 22, 1957 , and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) CLINTON, MD. DATE SIGNED FEB 23, 1957							
ACTUAL SIGNATURE Arthur Shaver Jr.		M.D. ARTHUR SHAVER JR. M.D. CLINTON, MD.					
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. M.D. CLINTON, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-25-57		22c. NAME OF CEMETERY OR CREMATORY Bells Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Camp Springs Md	
23. FUNERAL DIRECTOR'S SIGNATURE Summers Bros.		ADDRESS 1461 - Wood Hope Rd SE Wash. DC.		24a. RECD BY REGISTRAR FEB 26 1957		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

BUREAU V. S.

FEB 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG211 3-4-57 et

02082

2065

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>Bab's Track Maryland Farm</u>			
3. NAME OF DECEASED (Type or print) First <u>Fred (Alfred)</u> Middle <u>Delisle</u> Last <u>Bab's Track</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 Jan 1894</u>		9. AGE (In years lost birthday) yrs. <u>63</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horse Trainer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Horse Race</u>		11. BIRTHPLACE (State or foreign country) <u>Laconia N.H.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Xavier Delisle</u>				14. MOTHER'S MAIDEN NAME <u>Celanire Landry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>world war 1</u>		17. INFORMANT Address <u>Earl Brough 231 Court St Laconia N.H.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberc Pneumonia upper</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-14</u> , 1957, to <u>2-16</u> , 1957, that I last saw the deceased alive on <u>2-16</u> , 1957, and that death occurred at <u>1230 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>2-16-57</u>							
ACTUAL SIGNATURE <u>George Haggloge</u> M.D. <u>3717-3844</u>				PHYSICIAN'S NAME (Type) <u>2-16-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		22d. LOCATION (City, town, or county) (State) <u>Laconia N.H.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> ADDRESS <u>4812 Ga Ave DC</u>				24a. RECEIVED BY REGISTRAR <u>Feb 25 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

RECEIVED
FEB 25 1957
BUREAU V. S.

1 M
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2066 CERTIFICATE OF DEATH

Reg. Dist. No.

02083x39

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel Sanitarium				d. STREET ADDRESS 804 North Broadway			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MARY First F. Middle EASTWOOD Last				4. DATE OF DEATH February 28 19 57			
5. SEX Female		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 30-1860 96	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME BENEDICT DOUGLAS				14. MOTHER'S MAIDEN NAME FRANCES HABBER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO.			
17. INFORMANT Hospital records: Laurel Sanitarium				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia and 422.1 DUE TO arteriosclerotic cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic brain syndrome associated with (c) cerebral arteriosclerosis with psychotic reaction						INTERVAL BETWEEN ONSET AND DEATH 2 days many years many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 19 56 , to February 28 19 57 , that I last saw the deceased alive on February 28 19 57 , and that death occurred at 9:10 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Erika P. Kraemer				ADDRESS (Street, city or town, state) Laurel Sanitarium DATE SIGNED Feb 28-1957			
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER				State Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-4-57		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24. REC'D BY REGISTRAR MAK 4 1957		24b. REGISTRAR'S SIGNATURE Mellie N. Brasher	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02084

Reg. Dist. No.

2067

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arden d. STREET ADDRESS 3rd. Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Karen Edmonds First Middle Last				4. DATE OF DEATH February 28, 1957 Month Day Year			
5. SEX Female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH August 22, 1956		9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months 6 Days 8 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Floyd Edmonds				
14. MOTHER'S MAIDEN NAME Gloria Holmes			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				
16. SOCIAL SECURITY NO.			17. INFORMANT Gloria Edmonds; same address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO 491X Conditions, if any, which gave rise to immediate cause (b) Bronchopneumonia (c), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER February 28, 1957				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/2/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn			
22d. LOCATION (City, town, or county) Washington D.C.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Henry S. Washington 467 1st. N.W. Wash. D.C.</i>				24a. REC'D BY REGISTRAR DATE MAR 5 57			
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

99

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2

2

2677329XV4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: George ...

AGE: 70.0 ...

PLACE OF DEATH: ...

DATE OF DEATH: ...

TIME OF DEATH: ...

CAUSE OF DEATH: ...

IMMEDIATE CAUSE OF DEATH: ...

UNDERLYING CAUSE OF DEATH: ...

DETAILED HISTORY: ...

PHYSICIAN'S SIGNATURE: ...

BUREAU V. S.

MAR 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
: 2068
CERTIFICATE OF DEATH

Reg. Dist. No.

02085
245

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park 14</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Leland Memorial Hospital</i>		d. STREET ADDRESS <i>4912 Branchville Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Caroline May Feigheue</i>		4. DATE OF DEATH Month Day Year <i>February 25 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-28-1892</i>
9. AGE (In years last birthday) <i>84</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James K. Riddle</i>		14. MOTHER'S MAIDEN NAME <i>Emma Loveless</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>332x</i>	
17. INFORMANT <i>Mary I Chaney</i>		Address <i>4912 Branchville Rd. College Park Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction, Edema</i> 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Infarction & Left Hemiplegia</i> (c) <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. s. p. m. Month, Day, Year <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-1-57</i> , 1957, to <i>2-25-57</i> , 1957, that I last saw the deceased alive on <i>2-24-57</i> , 1957, and that death occurred at <i>6:15</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. Etienne</i>		ADDRESS (Street, city or town, state) <i>College Park Md.</i>	
PHYSICIAN'S NAME (Type) <i>DR. ETIENNE</i>		DATE SIGNED <i>2-25-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb 27, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Ammendale Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Beltsville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	
24a. REC'D BY REGISTRAR <i>James Severy</i>		24b. REGISTRAR'S SIGNATURE <i>James Severy</i>	
DATE <i>FEB 28 1957</i>			

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF BIRTH _____		PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF INTERMENT _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CORONER _____		SIGNATURE OF REGISTRAR _____	
SIGNATURE OF WITNESS _____		SIGNATURE OF WITNESS _____		SIGNATURE OF WITNESS _____	

BUREAU V. S.

FEB 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02086

Reg. Dist. No.

2069

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Garrett Middle Wayne Last Fincham				4. DATE OF DEATH Month Feb. Day 20, Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1954	
9. AGE (In years last birthday) 2 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Ashby Fincham				14. MOTHER'S MAIDEN NAME Dorothy Jean Fowler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Father; same address.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Waterhouse-Friderichsen Syndrome DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 20, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cemetery		22d. LOCATION (City, lawn, or county) (State) Collington, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. Witt Donaldson Laurel, Md.				24a. REC'D BY REGISTRAR FEB 25 57		24b. REGISTRAR'S SIGNATURE Witt	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

504 V. B. B.

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For more information

1997

[illegible]

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02087

2054

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	c. LENGTH OF STAY IN 1b <u>3 1/2</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7404 WILLOW DRIVE</u>		d. STREET ADDRESS <u>7404 WILLOW DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>LOUIS</u> First <u>ERNEST</u> Middle <u>FRANKE</u> Last		4. DATE OF DEATH <u>Feb 12</u> Month <u>12</u> Day <u>1957</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 30/1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM E. FRANKE</u>		14. MOTHER'S MAIDEN NAME <u>LENA C. SCHNEBEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>LENA E. KING</u>		Address <u>TAKOMA PK, MD</u> <u>7307 GLENVIEW DR.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Former hypertension, former cerebral hemorrhage</u> DUE TO (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>260X Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> to <u>Feb 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 11</u> , 19 <u>56</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John N. Andrews</u> M.D.		ADDRESS (Street, city or town, state) <u>9601 Colesville Rd</u> DATE SIGNED <u>2-12-57</u>	
PHYSICIAN'S NAME (Type) <u>John N. Andrews M.D.</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 15/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS</u>		ADDRESS <u>Co-Riverdale, MD</u>	
24a. REC'D BY REGISTRAR <u>2/14/57</u>		24b. REGISTRAR'S SIGNATURE <u>James L. L...</u>	

CERTIFICATE OF DEATH



Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint, illegible markings.

BUREAU V. S.

FEB 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2070

CERTIFICATE OF DEATH

02088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 23 Feb 1957			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS 62 D Ridge Rd.			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Furr				4. DATE OF DEATH Month Feb Day 23 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 Feb., 1957	9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2 Days 1	IF UNDER 24 HRS. Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --			10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Md		
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME James Furr				14. MOTHER'S MAIDEN NAME Joan Baldwin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Hospital records Cheverly Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) --							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 23 , 19 57 , to Feb 23 , 19 57 , that I last saw the deceased alive on Feb 23 , 19 57 , and that death occurred at 4:17 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Laurel M. D.				ADDRESS (Street, city or town, state) Laurel Md		DATE SIGNED 2/25/57	
PHYSICIAN'S NAME (Type) Laurel M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/57		22c. NAME OF CEMETERY OR CREMATORY St Johns Cemetery		22d. LOCATION (City, town, or county) (State) Beltville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Basels Sons				ADDRESS 2440 Beltsville Rd		24b. REGISTRAR'S SIGNATURE Overman	
24a. REC'D BY REGISTRAR FEB 27 57				DATE			

02089

CERTIFICATE OF DEATH

Reg. Dist. No.

134

2105

1. PLACE OF DEATH a. COUNTY Pr. George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's.			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Rt. # 1, Box 485 Clinton				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Rt. # 1, Box 485 Clinton, Md.			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First WILLIAM Middle A. Last GALLAHAN		4. DATE OF DEATH Month February Day 16 Year 19 57			
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19-1865		9. AGE (In years last birthday) yrs. 91	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William M. Gallahan				14. MOTHER'S MAIDEN NAME Janette Clubb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Wm. A. Gallahan Jr. Rt #1, Box 485 Clinton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 522x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY CONGESTION DUE TO (c) YEARS						INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 14, 1957 , to FEB. 16, 1957 , that I last saw the deceased alive on FEB. 16, 1957 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Chen M.D.				ADDRESS (Street, city or town, state) ACCOKEEK			
PHYSICIAN'S NAME (Type) PAUL CHEN				DATE SIGNED MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 18-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers				ADDRESS 1661- Good Hope Rd. SE		24a. REC'D BY REGISTRAR FEB 18 1957	
						24b. REGISTRAR'S SIGNATURE Carrie Campbell	
Washington, D.C.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician		11. Signature of Registrar		12. Date of Registration	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02090

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5105- H Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Cecilia Minnie Oluth</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28, 1899</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>David Crumbacher</u>		14. MOTHER'S MAIDEN NAME <u>Mary Harvey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes-no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Edward Adam Oluth, same as #</u>	
17. INFORMANT <u>Edward Adam Oluth, same as #</u>		Address <u>same as #</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb 16, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMPH BALTIMORE MD</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clarence F. Hoffman</u>		ADDRESS <u>3218 Hudson St</u>	
24a. REC'D BY REGISTRAR <u>2-18-57</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

RECEIVED

FEB 19 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03235

2072

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHATELAIN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 SUITLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.				d. STREET ADDRESS 1 5500 N.E. VIEW DRIVE			
3. NAME OF DECEASED (Type or print) First BABY BOY Middle GOINGS Last GOINGS				4. DATE OF DEATH Month FEB. Day 10 Year 19 57			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH feb. 10, 1957	
9. AGE (In years last birthday) yrs. 45		IF UNDER 1 YEAR Months 1 Days 45		IF UNDER 24 HRS. Hours 1 Min. 45			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Buren Haywood Goings				14. MOTHER'S MAIDEN NAME Carolyn Cutz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO (c) Pneumonia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2-10, 1957 , to 2-10, 1957 , that I last saw the deceased alive on 2-10, 1957 , and that death occurred at 2:55 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Perkins				ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville 2/47			
DATE SIGNED 2/10/57							
PHYSICIAN'S NAME (Type) Dr. John Perkins							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb 1957		22c. NAME OF CEMETERY OR CREMATORY Prince Georges Sanitary	
22d. LOCATION (City, town, or county) (State) Cherry Hill							
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Perkins				ADDRESS Adelphi		24a. REC'D BY REGISTRAR DATE MAR 12 '57	
24b. REGISTRAR'S SIGNATURE Perkins							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077/344XV2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02091

Reg. Dist. No. 234

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 1 Box # 23		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROY LEONARD HADLEY		4. DATE OF DEATH February 26th 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20/1897
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Leavenworth, Kan.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Chester Lee Hadley		14. MOTHER'S MAIDEN NAME Aver Belle Layman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW1		16. SOCIAL SECURITY NO. 579-07-5137	
17. INFORMANT Anna Belle Devey		Address Route #1 Box 122 Accokeek, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO 981X Conditions, if any, which gave rise to immediate cause (b) Gun shot wound of the chest (c), stating the underlying cause lost. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot with a 25 calibre revolver	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 2/26 1957 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Accokeek P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/1957	
22c. NAME OF CEMETERY OR CREMATORY Valley View Cemetery		22d. LOCATION (City, town, or county) (State) Nokesville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Carrie Campbell	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - ST. LOUIS, MO.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES EARL RAY		MALE		35		APRIL 4, 1968	
PLACE OF DEATH		CITY		STATE		COUNTRY	
ST. LOUIS, MISSOURI		ST. LOUIS		MISSOURI		UNITED STATES OF AMERICA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
NONE		FIREARM WOUND		SUICIDE		JAMES EARL RAY	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF WITNESS	
APRIL 4, 1968		10:00 AM		ST. LOUIS, MISSOURI		JAMES EARL RAY	

BUREAU V. S.

MAR 1 1967

RECEIVED

2073

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>Box 80</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Hardesty</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 Jan 57</u>
9. AGE (In years last birthday) yrs. <u>17</u>		IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		<u>Maryland</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Hardesty, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Tippet</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Edward Hardesty, Jr.</u>		Address <u>Rt. #2, Box 55 Upper Marlboro, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden cardiac arrest</u> 754.1 DUE TO <u>Large Patent Ductus Arteriosus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Large Patent Ductus Arteriosus</u> DUE TO (c) <u>Large Patent Ductus Arteriosus</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/16</u> , 1957, to <u>2/2</u> , 1957, that I last saw the deceased alive on <u>2/2</u> , 1957, and that death occurred at <u>3:25</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.		<u>College Park Md.</u>	
PHYSICIAN'S NAME (Type) <u>Thomas A. Christensen</u>		<u>College Park Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/4/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Bess</u> ADDRESS <u>Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>Waldorf, Md.</u>	
24b. REGISTRAR'S SIGNATURE <u>Waldorf, Md.</u>		DATE <u>FEB 6 57</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 6 FEB

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02093

Reg. Dist. No. 130

2107

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville			c. LENGTH OF STAY IN 1b Transient			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5112 Sunnyside Avenue				d. STREET ADDRESS 4817 Russell Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Albert Middle George Last Heath, Sr.				4. DATE OF DEATH Month February Day 10 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1901		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Optician		10b. KIND OF BUSINESS OR INDUSTRY Optical		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Heath				14. MOTHER'S MAIDEN NAME Mattie Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-03-6304		17. INFORMANT Address Albert George Heath, Jr. Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 250X (b) Cardiovascular renal disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington, D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home				ADDRESS Mt. Rainier		24a. REC'D BY REGISTRAR FEB 13 1957	24b. REGISTRAR'S SIGNATURE John A. Smith

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain in writing the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MD-100 (REV. 1-78) (1-78)

BUREAU V. S.

FEB 13 1957

RECEIVED

2050 CERTIFICATE OF DEATH

02094

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6621 23rd Ave.		d. STREET ADDRESS 6621-23rd Ave	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM - HEIN		4. DATE OF DEATH Month Day Year Feb 18 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15-1899
9. AGE (In years last birthday) 57		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Grocer		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joshua Benjamin	
14. MOTHER'S MAIDEN NAME Sarah Frieda-		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No X	
16. SOCIAL SECURITY NO. 577-50-6766		17. INFORMANT Henry Rubin, son in law Address 233-12th St S.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Central Atherosclerotic Accident DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 5, 1955, to Jan 22, 1957, that I last saw the deceased alive on Jan 22, 1957, and that death occurred at 7:00 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Harold L. Hirsch		M.D. 1635 Mass Ave N.W. Wash DC	
PHYSICIAN'S NAME (Type) HAROLD L. HIRSCH		DATE SIGNED 2/19/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19-57	
22c. NAME OF CEMETERY OR CREMATORY George Washington Memorial		22d. LOCATION (City, town, or county) (State) Hyattsville Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Goldberg Funeral Home Wash DC		24a. REC'D BY REGISTRAR DATE FEB 19 1957	
24b. REGISTRAR'S SIGNATURE Jas. E. Lewis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Rev. 10

BUREAU V. S.

FEB 19 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)				c. LENGTH OF STAY IN 1b 69 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				e. STREET ADDRESS 53 - Myrtle St., N.E.			
3. NAME OF DECEASED (Type or print) First Daisy Middle Holmes Last Holmes				4. DATE OF DEATH Month Feb. Day 26 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/25/13	
9. AGE (In years last birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton Garland				14. MOTHER'S MAIDEN NAME Lela Ridley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-18-5391		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial adenocarcinoma with metastasis to both lungs, meninges, adrenal glands, & spleen 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 19 , 19 56 , to Feb. 26 , 19 57 , that I last saw the deceased alive on Feb. 26 , 19 57 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Moe Weiss				ADDRESS (Street, city or town, state) Glenn Dale Hospital, Glenn Dale, Maryland			
PHYSICIAN'S NAME (Type) Moe Weiss				DATE SIGNED 2/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/2/57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Sturges				ADDRESS 82 H N E		24a. REC'D BY REGISTRAR DATE 2/27/57	
				24b. REGISTRAR'S SIGNATURE d. H. Hensley			

STATE DEPARTMENT OF HEALTH

MAR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02096

Reg. Dist. No.

2974

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 31 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 4729 68th Ave		d. STREET ADDRESS 1 Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LeRoy Middle Caleb Last Hoover				4. DATE OF DEATH Month February Day 23 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1917		9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months 39 Days 39 Hours 39 Min.	IF UNDER 24 HRS. Months 39 Days 39 Hours 39 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Laboratory		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Hoover				14. MOTHER'S MAIDEN NAME Bessie Walters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 11		17. INFORMANT Address Jeanette Dunn, 12823 Lacy Drive, Silver Springs			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Surgical shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Operation for lacerated liver, gall bladder, gastro hepatic and gastro cholic ligaments. (c) gastro hepatic and gastro cholic ligaments.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was driver of an automobile in collision with another. Surgery for injuries.					
20c. TIME OF INJURY Month, Day, Year 4.17 2-22-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Cottage City, Pr. Geo. Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		February 24, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE FEB 28 57	
				24b. REGISTRAR'S SIGNATURE Rufus			

MEDICAL CERTIFICATION

77

1

16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MISSOURI STATE DEPARTMENT OF HEALTH - BUREAU OF
 MEDICAL EXAMINERS' CERTIFICATE OF DEATH

Name of Deceased: James Earl Ray Age: 35 Sex: Male Race: White

Address: 1122 South 1st St., St. Louis, Mo.

Place of Death: St. Louis, Mo.

Date of Death: April 4, 1968

Time of Death: 2:01 PM

Signature of Physician: Dr. J. Edgar Hoover

Signature of Medical Examiner: Dr. J. Edgar Hoover

Signature of Coroner: James Earl Ray

Signature of Registrar: James Earl Ray

Signature of Medical Examiner: James Earl Ray

Signature of Coroner: James Earl Ray

BUREAU V. 2

FEB 28 1967

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 243

2109

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington 47x.3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie				c. LENGTH OF STAY IN 1b Transient			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bowie Race Track				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Raymond Middle Lee Last Hudson				4. DATE OF DEATH Month Feb. Day 12 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 6, 1897	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph H. Hudson		14. MOTHER'S MAIDEN NAME Bessie Dennison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 716-03-1175		17. INFORMANT Charles R. Hudson; 1558 41st St., S.E., Wash., D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED Feb. 12, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 2-15-57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE 300-4th St N.E.				24a. REC'D BY REGISTRAR D.C. 2/14/57		24b. REGISTRAR'S SIGNATURE John W. Youngling	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

STANDARD STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		35	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1957		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JAN 14 1957

RECEIVED

2075

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY <i>B.R. Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>B.R. Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale Md.</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eugene Island Memorial</i>		d. STREET ADDRESS <i>1440 Beechwood</i>	
3. NAME OF DECEASED (Type or print) <i>ELIZABETH P HUTTON</i>		4. DATE OF DEATH <i>Feb 9 1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 27, 1883</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ill</i>	
11. BIRTHPLACE (State or foreign country) <i>Ill</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>David A. Pollock</i>		14. MOTHER'S MAIDEN NAME <i>Marion Douglas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i>		<i>1 day</i>	
420.1 DUE TO <i>Acute Myocardial Infarction</i>		<i>6 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Crowned</i>		<i>2 days</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-1</i> , 1957, to <i>Feb 9</i> , 1957, that I last saw the deceased alive on <i>2-9</i> , 1957, and that death occurred at <i>5 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.C. Etienne</i>		DATE SIGNED <i>2-9-57</i>	
PHYSICIAN'S NAME (Type) <i>W.C. ETIENNE</i>		ADDRESS (Street, city or town, state) <i>4713 Perryway Rd College Park, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Feb 12, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>Bladensburg Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. William Lee</i>		ADDRESS <i>300-44th St</i>	
24a. REC'D BY REGISTRAR <i>Ms. Joe Bener</i>		24b. REGISTRAR'S SIGNATURE <i>Ms. Joe Bener</i>	

BUREAU V. S.

14 1957

RECEIVED

2076

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>20 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>5103 43rd Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Elizabeth</u> Last <u>Jarboe</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 7, 1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Frank M. Beall</u>				14. MOTHER'S MAIDEN NAME <u>Alice R. Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mary L. Jarboe Hyattsville, Maryland.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>434.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Congestive Heart Failure</u> DUE TO (c) <u>Acute Congestive Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-15-</u> , 19 <u>57</u> , to <u>2-15-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>FEB 15TH</u> , 19 <u>57</u> , and that death occurred at <u>11²⁰ P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arnold A. Lear</u> M.D. <u>905 SHERIDAN ST.</u>				DATE SIGNED <u>2-15-57</u>			
PHYSICIAN'S NAME (Type) <u>ARNOLD A. LEAR</u>				<u>HYATTSTVILLE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Catholic Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland.</u>				24a. RECEIVED BY REGISTRAR <u>W. J. Smith</u>		DATE <u>2-18-57</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL PLACE		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF CEMETERY		23. SIGNATURE OF GRAVE		24. SIGNATURE OF MONUMENT	
25. SIGNATURE OF TOMB		26. SIGNATURE OF URN		27. SIGNATURE OF CASK	
28. SIGNATURE OF COFFIN		29. SIGNATURE OF CASK		30. SIGNATURE OF CASK	
31. SIGNATURE OF CASK		32. SIGNATURE OF CASK		33. SIGNATURE OF CASK	
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73. SIGNATURE OF CASK		74. SIGNATURE OF CASK		75. SIGNATURE OF CASK	
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97. SIGNATURE OF CASK		98. SIGNATURE OF CASK		99. SIGNATURE OF CASK	
100. SIGNATURE OF CASK		101. SIGNATURE OF CASK		102. SIGNATURE OF CASK	

RECEIVED
FEB 19 1957
BUREAU V. 5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2110

CERTIFICATE OF DEATH

02100

Reg. Dist. No. 724

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ACCOKEEK</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA V JEWELL</u>				4. DATE OF DEATH Month Day Year <u>FEB. 4 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 3, 1881</u>	
9. AGE (In years lost birthday) yrs. <u>76</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ROBERT JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>SARAH GARRAD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>BENJAMIN H. JEWELL</u> Address <u>Accokeek Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY INSUFFICIENCY</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>PARALYSIS AFTER APOPLEXY</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>YEARS</u> <u>10 MOS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-31-1957</u> , to <u>2-4-1957</u> , that I last saw the deceased alive on <u>FEB. 4 - 1957</u> , and that death occurred at <u>2:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Chen</u> M.D.				ADDRESS (Street, city or town, state) <u>Accokeek Maryland</u>			
PHYSICIAN'S NAME (Type) <u>PAUL CHEN M.D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holland Cemetery Raleigh, N.C.</u>		22d. LOCATION (City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros. 1661-Good Hope Rd SE</u>				24. RECEIVED BY REGISTRAR <u>FEB 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

BUREAU V. S.

FEB 6 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 139

2077

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY PRINCE GEORGE		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town) LAUREL		LENGTH OF STAY (in this place) May 56		CITY (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		TOWN 15-56-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS LAUREL SANITARIUM				STREET ADDRESS (If rural give location) 201 ST. LAURENCE DRIVE			
3. NAME OF DECEASED (Type or Print) ANNA R. JOHNSON				4. DATE OF DEATH 2 5 19 57			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH Oct 1, 1892	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME WILLIAM EVANS				14. MOTHER'S MAIDEN NAME LULA SEARS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) unk.		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS HOSPITAL RECORDS			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						9:30 AM 2-57	
450.0 IMMEDIATE CAUSE		(A) acute peripheral circulatory failure					
ANTECEDENT CAUSE(S)		DUE TO (B) intestinal obstruction				9:00 PM 2-4-57	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO (C) generalized arteriosclerosis with psychomotor				T 4 yrs ago	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. reaction to fractured right hip III biacetis medium.						IT Oct 1956	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1956, to 2-5, 1957, that I last saw the deceased alive on 2-5, 1957, and that death occurred at 11:20 M, from the causes and on the date stated above.							
SIGNATURE BRUCE P. KRAMER (ERIKA P. KRAMER)				ADDRESS (Street, city, town, state) Laurel Sanitarium Laurel Md		DATE SIGNED 2-5-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2/8/57		NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEMETERY		LOCATION (City, town, or county) ARLINGTON, VIRGINIA	
24. REC'D BY REGISTRAR DATE FEB 8-57		REGISTRAR'S SIGNATURE M. Brashear		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walker E. Humphrey, SILVER SPRING, MD			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF REGISTRAR	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CEMETERY		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTERS		20. SIGNATURE OF MUSICIANS		21. SIGNATURE OF GUESTS	
22. SIGNATURE OF OTHERS		23. SIGNATURE OF OFFICIALS		24. SIGNATURE OF OTHERS	
25. SIGNATURE OF OTHERS		26. SIGNATURE OF OTHERS		27. SIGNATURE OF OTHERS	
28. SIGNATURE OF OTHERS		29. SIGNATURE OF OTHERS		30. SIGNATURE OF OTHERS	
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73. SIGNATURE OF OTHERS		74. SIGNATURE OF OTHERS		75. SIGNATURE OF OTHERS	
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97. SIGNATURE OF OTHERS		98. SIGNATURE OF OTHERS		99. SIGNATURE OF OTHERS	
100. SIGNATURE OF OTHERS		101. SIGNATURE OF OTHERS		102. SIGNATURE OF OTHERS	

RECEIVED
FEB 11 1957
BUREAU V. S.

NOTIFICATION
The undersigned hereby certifies that the above is a true and correct copy of the original record of the death of the deceased named herein, as the same appears in the records of the State Department of Health, Baltimore, Maryland, and that the same has been duly filed for the purpose of giving notice to the public of the death of the deceased named herein.

2111

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights				c. LENGTH OF STAY IN 1b 3 Yrs 6 Mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 5904 - 24th. Ave., S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ELSIE G. JOHNSON				4. DATE OF DEATH Feb. 26th. 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 29-1878	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mark Murray				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs Robert M. Moore Address 5904- 24th Ave., Hillcrest HGT.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 Hours 2 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan. 3rd. 1957 , to Feb. 2nd. 1957 , that I last saw the deceased alive on Feb. 2nd. 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David S. Gordon				ADDRESS (Street, city or town, state) 5731- 23rd. Parkway S.E.			
DATE SIGNED Feb. 2nd. 1957							
PHYSICIAN'S NAME (Type) DAVID S. GORDON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 1st 57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers				ADDRESS 1601- Good Hope Rd. S.E. Washington, D.C.		24a. REC'D BY REGISTRAR DATE FEB 28 57	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

УЗДІК

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100

504

100

BUREAU V. S.

FEB 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2078

CERTIFICATE OF DEATH

Reg. Dist. No.

02103

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood				c. LENGTH OF STAY IN 1b 34			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4323-40 th Street				d. STREET ADDRESS 4323-40 th Street			
3. NAME OF DECEASED (Type or print) George Richard King				4. DATE OF DEATH Feb. 10 th 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/26, 1903	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman, Smith Contractor				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME George T. King				14. MOTHER'S MAIDEN NAME Susan E. Clementson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-078258		17. INFORMANT Otho T. King Brother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSION, MILD DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH INST 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1949, to Feb 1957, that I last saw the deceased alive on Feb 2, 1957, and that death occurred at 7 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Benjamin S. Miller 3824-34th Mt Rainier Md Feb 11 1957 PHYSICIAN'S NAME (Type) BENJAMIN S MILLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home, Inc.				ADDRESS Mt Rainier, Md		REC'D BY REGISTRAR DATE 2/13/57	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

RECEIVED
 FEB 13 1957
 BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02104

Reg. Dist. No. *ny*

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount Heights		c. LENGTH OF STAY IN lb Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sheriff Road, in front of 6300.		d. STREET ADDRESS 4431 Hayes Street, N.E.	
3. NAME OF DECEASED (Type or print) Albert Latimer		4. DATE OF DEATH Month February Day 2 Year 19 57	
5. SEX Male	6. COLOR OR RACE coloree	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-12
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ed. Latimer		14. MOTHER'S MAIDEN NAME Kitty May	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Fannie Mary Latimer; same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured skull and laceration of liver DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apedestrian, struck by an automobile.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 12-10-57 2-2-57 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Fairmount Heights, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL-CREATION. REMOVAL (Specify) 2-7-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Elbertson Georgia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Washington</i>		ADDRESS 467 N st. NW.	
24a. REC'D BY REGISTRAR 2-13-57		24b. REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - JULY 12, 1937
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. McManis, Jr.	
Sex		Male	
Age		34	
Date of Death		July 12, 1937	
Place of Death		Home, 1031 River Street, St. Louis, Mo.	
Cause of Death		Acute myocardial infarction (heart attack)	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. 2

FEB 14 1937

RECEIVED

INSTRUCTIONS

1 **1** **1**

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02105

2113 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>upper Marlboro</u> TOWN <u>6 inch</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Ad Co</u> ✓ CITY (If outside corporate limits, write RURAL and give nearest town) <u>juvel</u> TOWN <u>02x02</u> STREET ADDRESS (If rural give location) <u>Maryland</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Lois</u> (Middle) <u>Plummer</u> (Last) <u>Wood Leitch</u>				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>22</u> (Year) <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct 29 1880</u>	9. AGE last birthday <u>76</u> yrs.	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Plummer</u>				14. MOTHER'S MAIDEN NAME <u>Rosal Wood Leitch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <u>Mr Arthur Leitch Upper Marlboro Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>coronary artery disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-6-</u> , 19 <u>57</u> , to <u>2-22-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 21</u> , 19 <u>57</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Emily H. Wilson</u>		M.D. <u>Lottman, Md.</u>		DATE SIGNED <u>2-22-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 24 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		LOCATION (City, town, or county) (State) <u>Friendship Md.</u>	
24. REC'D BY REGISTRAR <u>Feb 22 1957</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W H Hutchins</u>		ADDRESS <u>Cummings Md</u>	

CERTIFICATE OF DEATH

Reg. No. 100

1. USUAL RESIDENCE, HOUSE OR DETACHED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF BURIAL

6. NAME OF BURIAL PLACE

7. NAME OF MINISTER

8. NAME OF CLERGYMAN

9. NAME OF CHURCH

10. NAME OF CEMETERY

11. NAME OF FUNERAL HOME

12. NAME OF UNDERTAKER

13. NAME OF COFFIN

14. NAME OF CASK

15. NAME OF CASK

16. NAME OF CASK

17. NAME OF CASK

18. NAME OF CASK

19. NAME OF CASK

20. NAME OF CASK

21. NAME OF CASK

22. NAME OF CASK

23. NAME OF CASK

24. NAME OF CASK

25. NAME OF CASK

26. NAME OF CASK

27. NAME OF CASK

28. NAME OF CASK

29. NAME OF CASK

30. NAME OF CASK

31. NAME OF CASK

32. NAME OF CASK

33. NAME OF CASK

34. NAME OF CASK

35. NAME OF CASK

36. NAME OF CASK

37. NAME OF CASK

38. NAME OF CASK

39. NAME OF CASK

40. NAME OF CASK

41. NAME OF CASK

42. NAME OF CASK

43. NAME OF CASK

BUREAU V. 3

MAR 4 1957

RECEIVED

2114

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Largo		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Enterprise Road & Central Avenue		/d. STREET ADDRESS Enterprise Road & Central Ave	
3. NAME OF DECEASED (Type or print) First Ada Middle Virginia Last Littleford		4. DATE OF DEATH Month February Day 6, Year 1957.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Tenent	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Hutchison		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ruby White		Box 106, Rt. #2., Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conjunctive Heart Failure 422.2 DUE TO Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary Anemia DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 wks 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1956 , to Jan 5, 1957 , that I last saw the deceased alive on Jan 5, 1957 , and that death occurred at 10P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James G. Sasscer M.D. Upper Marlboro, Md. 2/6/57.			
ACTUAL SIGNATURE James G. Sasscer		PHYSICIAN'S NAME (Type) James G. Sasscer, M.D. Upper Marlboro, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/9/57	22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery	22d. LOCATION (City, town, or county) (State) Forestville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE FEB 13 57	
24. REGISTRAR'S SIGNATURE W. H. Leach			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Residence	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Burial		Place of Burial		Cause of Burial	
Manner of Burial		Occupation		Residence	
Signature of Minister		Signature of Registrar		Signature of Coroner	
Date of Interment		Place of Interment		Cause of Interment	
Manner of Interment		Occupation		Residence	
Signature of Minister		Signature of Registrar		Signature of Coroner	
Date of Cremation		Place of Cremation		Cause of Cremation	
Manner of Cremation		Occupation		Residence	
Signature of Minister		Signature of Registrar		Signature of Coroner	

BUREAU V. S.

FEB 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02107

2079

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights 36	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 6117 Shadyside Avenue	
3. NAME OF DECEASED (Type or print) First Frank Middle Lucas Last Lucas		4. DATE OF DEATH Month Feb. Day 19 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Smil F. Lucas		Address 6128 Shadyside Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Feb 18, 57		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 Febr. 19, '57 to Febr. 19 , 19 57 , that I last saw the deceased alive on Feb. 19 , 19 57 and that death occurred at 11:00 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE William D. Rosson M.D.		5304 Annapolis Road	
PHYSICIAN'S NAME (Type) Dr. William Rosson		Bladensburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-23-57	22c. NAME OF CEMETERY OR CREMATORY Addison Chapel	22d. LOCATION (City, town, or county) (State) Chesapeake, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Chambers		ADDRESS 14 W. Chambers	
24a. RECEIVED BY REGISTRAR FEB 23 57		24b. REGISTRAR'S SIGNATURE W. Leach	

BUREAU V. S.

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051 CERTIFICATE OF DEATH

02108

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5614--30th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LENORE (LEONORE) Middle KATHERINE Last MAHAN		4. DATE OF DEATH Month February Day 26th , Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8th, 1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Pittsburgh, Penna.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Haler	
14. MOTHER'S MAIDEN NAME Anna Weitershausen		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address James I. Mahan, Jr. 5614--30th Ave., West Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the colon with meta- 153X DUE TO stasis to the liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 yr. (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 31 , 19 57 to Feb. 26 , 19 57 , that I last saw the deceased alive on Feb. 24 , 19 57 , and that death occurred at 4 p. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5432 Queens Chapel Road 2/26/1957			
ACTUAL SIGNATURE Ronald S. Fleischer		M.D. 5432 Queens Chapel Road 2/26/1957	
PHYSICIAN'S NAME (Type) Ronald S. Fleischer		West Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 1/1957	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE July 28 1957	
24b. REGISTRAR'S SIGNATURE Thos. Jas. Severe		deputy	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF FUNERAL HOME</p>		<p>16. SIGNATURE OF BURIAL SOCIETY</p>	
<p>17. SIGNATURE OF CHURCH</p>		<p>18. SIGNATURE OF CEMETERY</p>	
<p>19. SIGNATURE OF OTHER</p>		<p>20. SIGNATURE OF OTHER</p>	
<p>21. SIGNATURE OF OTHER</p>		<p>22. SIGNATURE OF OTHER</p>	
<p>23. SIGNATURE OF OTHER</p>		<p>24. SIGNATURE OF OTHER</p>	
<p>25. SIGNATURE OF OTHER</p>		<p>26. SIGNATURE OF OTHER</p>	
<p>27. SIGNATURE OF OTHER</p>		<p>28. SIGNATURE OF OTHER</p>	
<p>29. SIGNATURE OF OTHER</p>		<p>30. SIGNATURE OF OTHER</p>	
<p>31. SIGNATURE OF OTHER</p>		<p>32. SIGNATURE OF OTHER</p>	
<p>33. SIGNATURE OF OTHER</p>		<p>34. SIGNATURE OF OTHER</p>	
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<p>43. SIGNATURE OF OTHER</p>		<p>44. SIGNATURE OF OTHER</p>	
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<p>49. SIGNATURE OF OTHER</p>		<p>50. SIGNATURE OF OTHER</p>	
<p>51. SIGNATURE OF OTHER</p>		<p>52. SIGNATURE OF OTHER</p>	
<p>53. SIGNATURE OF OTHER</p>		<p>54. SIGNATURE OF OTHER</p>	
<p>55. SIGNATURE OF OTHER</p>		<p>56. SIGNATURE OF OTHER</p>	
<p>57. SIGNATURE OF OTHER</p>		<p>58. SIGNATURE OF OTHER</p>	
<p>59. SIGNATURE OF OTHER</p>		<p>60. SIGNATURE OF OTHER</p>	
<p>61. SIGNATURE OF OTHER</p>		<p>62. SIGNATURE OF OTHER</p>	
<p>63. SIGNATURE OF OTHER</p>		<p>64. SIGNATURE OF OTHER</p>	
<p>65. SIGNATURE OF OTHER</p>		<p>66. SIGNATURE OF OTHER</p>	
<p>67. SIGNATURE OF OTHER</p>		<p>68. SIGNATURE OF OTHER</p>	
<p>69. SIGNATURE OF OTHER</p>		<p>70. SIGNATURE OF OTHER</p>	
<p>71. SIGNATURE OF OTHER</p>		<p>72. SIGNATURE OF OTHER</p>	
<p>73. SIGNATURE OF OTHER</p>		<p>74. SIGNATURE OF OTHER</p>	
<p>75. SIGNATURE OF OTHER</p>		<p>76. SIGNATURE OF OTHER</p>	
<p>77. SIGNATURE OF OTHER</p>		<p>78. SIGNATURE OF OTHER</p>	
<p>79. SIGNATURE OF OTHER</p>		<p>80. SIGNATURE OF OTHER</p>	
<p>81. SIGNATURE OF OTHER</p>		<p>82. SIGNATURE OF OTHER</p>	
<p>83. SIGNATURE OF OTHER</p>		<p>84. SIGNATURE OF OTHER</p>	
<p>85. SIGNATURE OF OTHER</p>		<p>86. SIGNATURE OF OTHER</p>	
<p>87. SIGNATURE OF OTHER</p>		<p>88. SIGNATURE OF OTHER</p>	
<p>89. SIGNATURE OF OTHER</p>		<p>90. SIGNATURE OF OTHER</p>	
<p>91. SIGNATURE OF OTHER</p>		<p>92. SIGNATURE OF OTHER</p>	
<p>93. SIGNATURE OF OTHER</p>		<p>94. SIGNATURE OF OTHER</p>	
<p>95. SIGNATURE OF OTHER</p>		<p>96. SIGNATURE OF OTHER</p>	
<p>97. SIGNATURE OF OTHER</p>		<p>98. SIGNATURE OF OTHER</p>	
<p>99. SIGNATURE OF OTHER</p>		<p>100. SIGNATURE OF OTHER</p>	

BUREAU V. B.

MAR 4 1957

RECEIVED

2080

CERTIFICATE OF DEATH

02109

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE FLORIDA b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly,				c. LENGTH OF STAY IN 1b 1 Mo 27 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS LEESBURG 48X-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Maude Cox Vann Middle Manley Last Manley		4. DATE OF DEATH Month Feb. Day 17 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/16/79	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Attalla, Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George L. Cox				14. MOTHER'S MAIDEN NAME Charlotte Crisman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Homer King Vann, Olney, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X DUE TO GENERALIZED CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADENO CARCINOMA LEFT URETER DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos. 1 year.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 1956 to FEB 17 1957 , that I last saw the deceased alive on FEB 17 1957 , and that death occurred at 6:45 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donati Comeau		M.D. 3503 Perry St.		ADDRESS (Street, city or town, state) 2/17/57		DATE SIGNED	
PHYSICIAN'S NAME (Type) NORMAN DONATI COMEAU		DR. NORMAN DONATI COMEAU					
22a. BURIAL, CREMATION, TRANS. & BURIAL		22b. DATE THEREOF 2/19/57		22c. NAME OF CEMETERY OR CREMATORY FORREST CEMETERY		22d. LOCATION (City, town, or county) (State) GADSDEN, ALABAMA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR FEB 20 57	
				24b. REGISTRAR'S SIGNATURE Dr. C. L. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 6 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE 18

023104

1957

1850

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. RACE		13. ETHNIC ORIGIN		14. NATURALIZATION		15. CITIZENSHIP		16. RESIDENCE		17. DECEASED		18. DECEASED		19. DECEASED		20. DECEASED		21. DECEASED		22. DECEASED		23. DECEASED		24. DECEASED		25. DECEASED		26. DECEASED		27. DECEASED		28. DECEASED		29. DECEASED		30. DECEASED		31. DECEASED		32. DECEASED		33. DECEASED		34. DECEASED		35. DECEASED		36. DECEASED		37. DECEASED		38. DECEASED		39. DECEASED		40. DECEASED		41. DECEASED		42. DECEASED		43. DECEASED		44. DECEASED		45. DECEASED		46. DECEASED		47. DECEASED		48. DECEASED		49. DECEASED		50. DECEASED		51. DECEASED		52. DECEASED		53. DECEASED		54. DECEASED		55. DECEASED		56. DECEASED		57. DECEASED		58. DECEASED		59. DECEASED		60. DECEASED		61. DECEASED		62. DECEASED		63. DECEASED		64. DECEASED		65. DECEASED		66. DECEASED		67. DECEASED		68. DECEASED		69. DECEASED		70. DECEASED		71. DECEASED		72. DECEASED		73. DECEASED		74. DECEASED		75. DECEASED		76. DECEASED		77. DECEASED		78. DECEASED		79. DECEASED		80. DECEASED		81. DECEASED		82. DECEASED		83. DECEASED		84. DECEASED		85. DECEASED		86. DECEASED		87. DECEASED		88. DECEASED		89. DECEASED		90. DECEASED		91. DECEASED		92. DECEASED		93. DECEASED		94. DECEASED		95. DECEASED		96. DECEASED		97. DECEASED		98. DECEASED		99. DECEASED		100. DECEASED	
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BUREAU V. S.

FEB 20 1957

RECEIVED

2081

CERTIFICATE OF DEATH

02110

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 30 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. STREET ADDRESS 6117 Otis St.	
3. NAME OF DECEASED (Type or print) First George Middle KOK Last Mann		4. DATE OF DEATH Month Feb Day 16 Year 19 57	
5. SEX Male	6. COLOR OR RACE Chinese	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Sept. 1903
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State of foreign country) Calif		12. CITIZEN OF WHAT COUNTRY? yes U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Christabelle M. Mann Address 6117 Otis St. Landover, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive Heart Failure DUE TO (b) Old myocardial infarct DUE TO (c) Coronary Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Fibrosis			INTERVAL BETWEEN ONSET AND DEATH 2 months YEARS YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1,10A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George Habiage M.D. 3717-3 Ph. 6		ADDRESS (Street, city or town, state) DATE SIGNED 2/16/57	
PHYSICIAN'S NAME (Type) GEORGE HABIAGE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-19-1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Washington, D.C. ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 18 57	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, postcard should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

FEB 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or interment.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02111

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cederville</u> c. LENGTH OF STAY IN 1b <u>month</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mont Road</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Cederville</u> d. STREET ADDRESS <u>Mont Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Salomon</u> Middle <u>Elyah</u> Last <u>McDonnell</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Celove</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1899</u>
9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>7</u> Hours <u>19</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>South Carolina</u> 11. BIRTHPLACE (State or foreign country) <u>U S</u> 12. CITIZEN OF WHAT COUNTRY? <u>6</u>	
13. FATHER'S NAME <u>Gibb Mc Donnell</u>		14. MOTHER'S MAIDEN NAME <u>Caroline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>FRANCES HARVEY</u>	
17. INFORMANT <u>FRANCES HARVEY</u>		Address <u>411-3rd St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>universal charring burning of the body</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>INTERNAL BETWEEN ONSET AND DEATH</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>occupant of a house that burned down</u>	
20c. TIME OF INJURY Month, Day, Year <u>12</u> a. m. <u>2/7</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Cederville</u> (County) <u>P.S.</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		DATE SIGNED <u>Feb 7, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. E. Ernest Jones</u>		24a. REC'D BY REGISTRAR <u>DATE 2/9/57</u>	
ADDRESS <u>1432 York St</u>		24b. REGISTRAR'S SIGNATURE <u>D. H. Hedrick</u>	

MEDICAL CERTIFICATION

BUREAU V. 2

FEB 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2082

CERTIFICATE OF DEATH

Reg. Dist. No.

02112

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>MARIE</u> Last <u>Meyers</u>				4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 3/1881</u>	
9. AGE (In years last birthday) <u>75</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Peter LaVelle</u>			
14. MOTHER'S MAIDEN NAME <u>Ellen Garrity</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NONE</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>Hosp. Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>199.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PELVIC CARCINOMA</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS.</u> <u>2 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>14 NOV.</u> , 19 <u>56</u> , to <u>1 FEB</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1 FEB</u> , 19 <u>57</u> , and that death occurred at <u>8:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. J. Houmann</u>				ADDRESS (Street, city or town, state) <u>4404 QUEENSBURY RD RIVERDALE MD.</u>			
PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u>				DATE SIGNED <u>1 FEB '57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PITTSBURGH, PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber Co. Riverdale 3rd.</u>				ADDRESS <u>RIVERDALE MD.</u>		24. REGISTRAR'S SIGNATURE <u>James Leary</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1922		MOBILE		ALABAMA		U.S.A.		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
FEB 6 1968		FEDERAL BUREAU OF INVESTIGATION		WASHINGTON		D.C.		U.S.A.		FEB 6 1968		FEDERAL BUREAU OF INVESTIGATION		WASHINGTON		D.C.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
HEART DISEASE		SUICIDE		BUSINESSMAN		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

FEB 6 1957

RECEIVED

2083

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>9 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Gen Hosp.</u>				e. STREET ADDRESS <u>2331 Belview Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Clement</u> Middle <u>Briscoe</u> Last <u>MILBURN</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>31 Mar. 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. AGE (In years last birthday) <u>80</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>St. Mary's County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam XXXX Boat Captain (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
13. FATHER'S NAME <u>James Thomas Milburn</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Hewitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>				16. SOCIAL SECURITY NO. <u>578-05-4900</u>			
17. INFORMANT <u>Inez A. Parsons</u>				Address <u>Cheverly, Md. 2331 Belview Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate gland</u> DUE TO (b) <u>with multiple generalized</u> DUE TO (c) <u>metastases</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 15, 19 57</u> to <u>Feb 24, 19 57</u> that I last saw the deceased alive on <u>Feb 24, 19 57</u> , and that death occurred at <u>1, 30A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William D. Rosson M.D.</u>				ADDRESS (Street, city or town, state) <u>5304 Annapolis Road</u>			
PHYSICIAN'S NAME (Type) <u>William D. Rosson</u>				DATE SIGNED <u>Bladensburg, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2/27/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Pr. Geo. Co. Md.</u>				22e. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. ...</u>				ADDRESS <u>...</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 27 57</u>	
24b. REGISTRAR'S SIGNATURE <u>...</u>				24c. REGISTRAR'S SIGNATURE <u>...</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

FEB 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02114

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor		c. LENGTH OF STAY IN 1b 1/2 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1526 2 Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3406 37th Avenue				d. STREET ADDRESS 7 Locks Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur Middle Edward Last Miles				4. DATE OF DEATH Month February Day 20 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 30, 1877	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired contractor		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME —			
14. MOTHER'S MAIDEN NAME —				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. no				17. INFORMANT Address Lillian Elliott, 3406 37th Ave., Col. Manor.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Hypertension and arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED February 20, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Colmar Manor, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				ADDRESS		24a. REC'D BY REGISTRAR DATE 27 1957	
24b. REGISTRAR'S SIGNATURE d. H. Hedrick							

ALLIANCE STATE DEPARTMENT OF HEALTH—BIRMINGHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Doe	
Age		35 years	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Teacher	
Residence		1234 Main St., Birmingham, Ala.	
Cause of Death		Heart disease	
Manner of Death		Natural	
Time of Death		10:00 AM	
Date of Death		Feb 27, 1957	
Signature of Examiner		[Signature]	
Signature of Coroner		[Signature]	

BUREAU V. S.

FEB 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with
their registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02115

2117

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DISTRICT HEIGHTS</u>		c. LENGTH OF STAY IN 1b <u>23 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 DISTRICT HEIGHTS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7102 FOSTER ST.</u>				d. STREET ADDRESS <u>1 7102 FOSTER ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> First <u>ARTHUR</u> Middle <u>MITCHELL</u> Last				4. DATE OF DEATH Month <u>FEB.</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 16, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRIAL MAGISTRATE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BETHANY ILL.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>THOMAS L. MITCHELL</u>				14. MOTHER'S MAIDEN NAME <u>SARAH McGUIRE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-42-0596</u>		17. INFORMANT <u>MRS. NANCY A. MITCHELL - WIFE</u> Address <u>7102 FOSTER ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19 <u>50</u> to <u>2/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>February 19, 1957</u> , and that death occurred at <u>11:20P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>James I. Boyd</u> PHYSICIAN'S NAME (Type) <u>James I. Boyd</u>				M.D. <u>Forestville, Md</u> <u>2/19/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-23-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Southland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>				ADDRESS <u>577-11th St SE Wash. D.C.</u>		24. REC'D BY REGISTRAR <u>FB 25 1957</u>	
				25. REGISTRAR'S SIGNATURE <u>A. K. Hedrick</u>			

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES A. WILSON		65		M		W		1892		BALTIMORE		MD		USA				FEB 25 1957		BALTIMORE		MD		USA			
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE									
CAUSE OF DEATH		HEART DISEASE		CORONARY ARTERY DISEASE		MYOCARDIAL INFARCTION		ANGINA PECTORIS		HYPERTENSION		DIABETES		OBESITY		SMOKING		ALCOHOLISM		DRUGS		TRAUMA		SUICIDE		OTHER	
MANNER OF DEATH		NATURAL		ACCIDENT		HOMICIDE		SUICIDE		UNDETERMINED																	
SIGNATURE OF PHYSICIAN		J. A. WILSON		M.D.																							
SIGNATURE OF REGISTRAR		J. A. WILSON		M.D.																							

BUREAU V. S.

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 210 2-18-57 et

02116

CERTIFICATE OF DEATH

Reg. Dist. No.

2118

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Hghts.</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>		d. STREET ADDRESS <u>2500 Lyons</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>A</u> Last <u>Mooney</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-5-1871</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Martha Litton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Grace Richards Hillcrest Hghts Bld</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephritis, Chronic and Acute</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>1 yr</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9030 Fracture left hip 1 yr ago.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pl. slipped on floor at home 1 yr ago.</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>Mar. 15</u> 19 <u>57</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Wash D.C.</u>	
21. I certify that I attended the deceased from <u>April, 1957</u> to <u>2-9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-8</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John P. D'Angelo</u> M.D.				ADDRESS (Street, city or town, state) <u>4223 Sibra Hill Rd</u> DATE SIGNED <u>2-9-57</u>			
PHYSICIAN'S NAME (Type) <u>John P. D'Angelo M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A Mattingly</u>				ADDRESS <u>131-11 St</u>		24a. REC'D BY REGISTRAR <u>Feb 13 '57</u> 24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

U. S. OVER

1957 7-1

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02117

2084

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lillie Christine Moreland</u>				4. DATE OF DEATH <u>FEB. 24 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 20, 1897</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Freemock</u>		11. BIRTHPLACE (State or foreign country) <u>Freemock</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Benjamin F. Griffith</u>			
14. MOTHER'S MAIDEN NAME <u>Bertha Belle Phipps</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>Hillary C. Moreland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza Broncho pneumonia</u> 480X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>21 Feb</u> , 19 <u>57</u> , to <u>24 Feb</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>24 Feb</u> , 19 <u>57</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. B. Danner</u>				ADDRESS (Street, city, or town, state) <u>Upper Marlboro, Md.</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>25 Feb 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Lothian Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard O. Hendon</u>				24a. REC'D BY REGISTRAR DATE <u>2/28/57</u>			
24b. REGISTRAR'S SIGNATURE <u>W. J. Danner</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02118

2119

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belmead			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belmead		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7409 Upshur Street				d. STREET ADDRESS 7409 Upshur Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George First W. Middle Morris Last				4. DATE OF DEATH February Month 1 Day 19 Year 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/14/78	
9. AGE (In years lost, birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postmaster				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Morris				14. MOTHER'S MAIDEN NAME Mary Ann Lockwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Emily W. Morris, 7409 Upshur St. Belmead Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronosis of River DUE TO (c) 1 year? INTERVAL BETWEEN ONSET AND DEATH 1 year?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/16/1956 , to Feb 15 1957 , that I last saw the deceased alive on 1/31/57 , and that death occurred at 8:43 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1150 Connecticut ave Washington D.C. DATE SIGNED W. B. Sims ACTUAL SIGNATURE W. B. Sims M.D. Washington D.C. PHYSICIAN'S NAME (Type) W. B. Sims							
22a. BURIAL, CREMATION, REMOVAL (Specify) B urial		22b. DATE THEREOF 2/4/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D.C.				24a. REC'D BY REGISTRAR FEB 4 1957		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

CERTIFICATE OF DEATH

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

WHITE

EDUCATION

DATE

PLACE OF BIRTH

DATE OF DEATH

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FEB 4 1957

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2120

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park				c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8236 14th Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last KITTY MOVER				4. DATE OF DEATH Month Day Year FEB. 13 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/9/04	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk				10b. KIND OF BUSINESS OR INDUSTRY Hardware Store		11. BIRTHPLACE (State or foreign country) Morefield, W. Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Walter A. Malcolm				14. MOTHER'S MAIDEN NAME Permelia C. Pope			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-32-2529		17. INFORMANT Mr. Lee R. Mower, Jr., 12,014 Judson Rd. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 HOURS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hyattsville				20g. (County) Prince George's		20h. (State) Maryland	
21. I certify that I attended the deceased from 1-17-57 to 13 FEB, 1957, that I last saw the deceased alive on 13 FEB, 1957, and that death occurred at 9:20 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED H. R. Wolfe M.D. 905 SHERIDAN ST. HYATTSVILLE 2/13/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 2/13/57		22c. NAME OF CEMETERY OR CREMATORY Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE Feb 14 1957	
24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe				24c. DATE 2/13/57			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02120

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN lb 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Brentwood, Md.	
4. NAME OF DECEASED (Type or print) First Middle Last Brenda Sue Parks		4. DATE OF DEATH Month Day Year February 16, 19 57.	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1956
9. AGE (In years last birthday) yrs. 9		IF UNDER 1 YEAR Months Days Hours Min. 9 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Grady W. Parks		14. MOTHER'S MAIDEN NAME Reathel B. Mathias	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Grady W. Parks		Address Brentwood, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (b) 2nd. and 3rd, degree burns of body, 30 % (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute tracheobronchitis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Burns of body caused by spilling of steaming water from vaporizer	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 4:30 PM 2-16-1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Brentwood Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 17, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 2/18/57		22b. DATE THEREOF 2/18/57	
22c. NAME OF CEMETERY OR CREMATORY Ellijay		22d. LOCATION (City, town, or county) (State) Georgia.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Gasch's Sons Hyattsville, Maryland.		24a. REC'D BY REGISTRAR FEB 19 57 DATE	
24b. REGISTRAR'S SIGNATURE W. H. Leach			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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BUREAU V. E.

FEB 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02121

2121

CERTIFICATE OF DEATH

Reg. Dist. No. 720

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>University Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>University Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>7007 Colesville Road</i>		d. STREET ADDRESS <i>7007 Colesville Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Thomas Markel Pierce</i>		4. DATE OF DEATH <i>Feb 2 1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2 Jan 1870</i>
9. AGE (In years last birthday) <i>87</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired-Mechanics</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Westinghouse</i>	
11. BIRTHPLACE (State or foreign country) <i>Irwin Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Thomas Pierce</i>		14. MOTHER'S MAIDEN NAME <i>Margaret P. Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Russell U. Pierce-4827 Lexington Ave</i>		Address <i>Beltsville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute heart failure</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>generalized arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1955</i> to <i>2 Feb 1957</i> , that I last saw the deceased alive on <i>30 Jan 1957</i> , and that death occurred at <i>2a</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas E. McFlingly</i>		DATE SIGNED <i>2200 R.T. Ave N.E.</i>	
PHYSICIAN'S NAME (Type) <i>Thomas E. McFlingly MD</i>		<i>Wash. 15, D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>		22b. DATE THEREOF <i>2/4/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Irwin Union Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Irwin, Pennsylvania</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>		24a. REC'D BY REGISTRAR <i>2901 14th St. N.W.</i>	
24b. REGISTRAR'S SIGNATURE <i>John D. Smith</i>		DATE <i>FEB 4 1957</i>	

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		White		1900		New York		1957		New York		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Occupation		14. Education		15. Marital status		16. Date of marriage		17. Date of last contact		18. Date of last illness		19. Date of last examination		20. Date of last treatment		21. Date of last hospitalization		22. Date of last surgery		23. Date of last autopsy		24. Date of last necropsy	
Teacher		High School		Married		1920		1956		1957		1957		1957		1957		1957		1957		1957	
25. Date of death		26. Place of death		27. Cause of death		28. Manner of death		29. Signature of physician		30. Signature of registrar		31. Signature of informant		32. Date of death		33. Place of death		34. Cause of death		35. Manner of death		36. Signature of physician	
1957		New York		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		1957		New York		Heart Disease		Natural		[Signature]	

BUREAU V. 2

FEB 4 1957

RECEIVED

2086

CERTIFICATE OF DEATH

02122

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp</u>		d. STREET ADDRESS <u>6911- Dartmouth Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Donald</u> First <u>Simms</u> Middle <u>Porter</u> Last		4. DATE OF DEATH Month <u>Feb</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 27-1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>22</u> Hours <u>14</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Philip Porter</u>		14. MOTHER'S MAIDEN NAME <u>Lissy Stahl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2</u>	
17. INFORMANT <u>Chloe E. Porter</u> Address <u>College Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary defect</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-19</u> , 19 <u>40</u> to <u>2-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-22</u> , 19 <u>56</u> , and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Aaron Deitz</u> M.D.		ADDRESS (Street, city or town, state) <u>Hyattsville, Md.</u> DATE SIGNED <u>2-22-57</u>	
PHYSICIAN'S NAME (Type) <u>Aaron Deitz</u>		<u>HYATTSTVILLE-MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/25/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baden, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>27 57</u>	24b. REGISTRAR'S SIGNATURE <u>Deitz</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02123

Reg. Dist. No.

2087

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 1/2 hou		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Accokeek	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Box 599, Route 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First George Middle Everett Last Rawlett				4. DATE OF DEATH Month February Day 24, Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1901		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter		10b. KIND OF BUSINESS OR INDUSTRY Heating		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Irene Rawlett; same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John J. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED February 24, 1957			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-28-57		22c. NAME OF CEMETERY OR CREMATORY Edgar Hill Cem.		22d. LOCATION (City, town, or county) (State) Shutland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517-11 St. SE				24a. REC'D BY REGISTRAR FEB 27 57		24b. REGISTRAR'S SIGNATURE W. Beach	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
James O'Connell		February 27, 1957	
Sex		Age	
Male		40 years	
Race		Occupation	
Caucasian		I don't know	
Place of Birth		Place of Death	
New York City, N.Y.		New York City, N.Y.	
Usual Residence		Cause of Death	
New York City, N.Y.		Myocardial Infarction	
Date of Death		Time of Death	
February 27, 1957		10:00 A.M.	
Signature of Medical Examiner		Signature of Coroner	
[Signature]		[Signature]	
Print Name of Medical Examiner		Print Name of Coroner	
[Name]		[Name]	
Address of Medical Examiner		Address of Coroner	
[Address]		[Address]	

There is no autopsy to be performed.

External vascular accident

Internal

BUREAU V. S.

FEB 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02124

2122

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY PR. GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Pr. George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Morningside			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 505 Maple Road				d. STREET ADDRESS 505 Maple Road			
3. NAME OF DECEASED (Type or print) First EMMA Middle V Last RHODES				4. DATE OF DEATH Month FEB Day 3 Year 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 23-1876	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John T. Rabbitt				14. MOTHER'S MAIDEN NAME Elizabeth Mosley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT William R. Colegrove				Address 505 Maple Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 YRS.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Clinton Md.				(County) (State)			
21. I certify that I attended the deceased from JULY , 19 50 , to FEB 3 , 19 57 , that I last saw the deceased alive on FEB 3 , 19 57 , and that death occurred at 6:40 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Alfred R. Lapin M.D.				DATE SIGNED Feb 3-1957			
PHYSICIAN'S NAME (Type) ALFRED R. LAPIN M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Washington, D.C.				24a. REC'D BY REGISTRAR DATE 2-6-57		24b. REGISTRAR'S SIGNATURE Carrie F. Campbell	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02125

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro				c. LENGTH OF STAY IN 1b Ceder Heights X2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) County Jail				d. STREET ADDRESS 1003 62nd Place 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) JAMES WILLIS RIDGLEY Jr.				4. DATE OF DEATH February 16 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Aug 1936		9. AGE (In years last birthday) 20 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Bldg. Const.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Ridgley Sr.				14. MOTHER'S MAIDEN NAME Agnes I. Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Address Agnes Ridgley (Mother) Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X Congestive heart failure's DUE TO Labor pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Labor pneumonia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb 16, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/57		22c. NAME OF CEMETERY OR CREMATORY Ridgley Meth Ceme.		22d. LOCATION (City, town, or county) (State) Landover, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Glenn S. Dewal				ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR FEB 19 57	
				24b. REGISTRAR'S SIGNATURE W. H. ...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF TEXAS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		Feb 18, 1957	
Place of Birth		Occupation		Cause of Death		Manner of Death	
New York City		Teacher		Heart Disease		Natural	
Residence		Hospital		Physician		Coroner	
123 Main St.		St. Mary's		Dr. Smith		Mr. Jones	
City		County		State		Zip	
Houston		Harris		Texas		77001	
Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

FEB 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02126

Reg. Dist. No.

ny 3

2124

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie				c. LENGTH OF STAY IN 1b transient			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bowie Race Track				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> 69x-3 Brooklyn			
f. STREET ADDRESS 8224 Bay Parkway				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Phillip Middle Last Ripstein				4. DATE OF DEATH Month February Day 23 Year 19 57			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1901	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dress maker		10b. KIND OF BUSINESS OR INDUSTRY Garment		11. BIRTHPLACE (State or foreign country) New York State		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willaim Ripstein				14. MOTHER'S MAIDEN NAME Miriam ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Barbara Ripstein; same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 23, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-57		22c. NAME OF CEMETERY OR CREMATORY New Montpelier Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn N.Y.	
23. GENERAL DIRECTOR'S SIGNATURE Jack Lewis				ADDRESS 2100 Ertaw Pl		24. REC'D BY REGISTRAR FEB 25 1957	
				24b. REGISTRAR'S SIGNATURE Agnes Jungling			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

STATE OF NEW YORK
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John E. Malone		Male		35	
Place of Birth		Race		Color	
New York		Caucasian		White	
Date of Death		Time of Death		Place of Death	
Feb. 25, 1957		10:30 P.M.		New York	
Cause of Death		Manner of Death		Signature of Medical Examiner	
Coronary Thrombosis		Natural		[Signature]	
Contributing Cause		Signature of Coroner		Signature of Physician	
None		[Signature]		[Signature]	

RECEIVED
 FEB 25 1957
 BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **215**

2988

02127

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52x3 Hobart d. STREET ADDRESS 3958 Normal Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Antonio Middle Last Roque Jr.				4. DATE OF DEATH Month February Day 17 Year 19 57									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 3, 1937		9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor, U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY U.S.S. Ingraham				11. BIRTHPLACE (State or foreign country) Indiana				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Antonio Roque						14. MOTHER'S MAIDEN NAME Mary Babinchak							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Currently (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 317-36-7858				17. INFORMANT Navy Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Lacerations of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Automobile accident (c) </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in automobile which collided with a stone wall.	
20c. TIME OF INJURY Month, Day, Year Hour 11:30 p. m. 2-17-57 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Beltsville Pr. Geo. Md.		(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.													
ACTUAL SIGNATURE <i>John T. Maloney</i>						DATE SIGNED							
EXAMINER'S NAME (Type) John T. Maloney, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 18, 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-23-57		22c. NAME OF CEMETERY OR CREMATORY Private				22d. LOCATION (City, town, or county) Hobart, Indiana (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i> ADDRESS R.A. Pumphrey, 755 Wisconsin Ave., Bethesda, Md.						24a. REC'D BY REGISTRAR DATE 2-19-57		24b. REGISTRAR'S SIGNATURE <i>George S. Sweeney</i>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BARNHART, IS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Robert		D. O. B.	
Place of Death		Cause of Death	
Home		Heart disease	
Age		Sex	
60		Male	
Race		Occupation	
White		Farmer	
Marital Status		Previous Illnesses	
Married		Hypertension	
Date of Birth		Date of Admission to Hospital	
January 1, 1907		January 1, 1957	
Place of Birth		Date of Discharge	
Illinois		January 1, 1957	
Date of Death		Place of Death	
January 1, 1957		Home	
Cause of Death		Manner of Death	
Heart disease		Natural	
Detailed Description of Cause of Death		Detailed Description of Manner of Death	
Coronary artery disease, atherosclerosis, myocardial infarction.		No suspicious circumstances.	
Autopsy performed		Signature of Medical Examiner	
Yes		J. A. Smith	
Date of Autopsy		Signature of Coroner	
January 1, 1957		J. B. Jones	

Examiner's Certificate of Death

BUREAU V. S.

FEB 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02128

Reg. Dist. No.

2089

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg c. LENGTH OF STAY IN 1b 15 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4103 53rd Place				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Bladensburg d. STREET ADDRESS 4103 53rd Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Elias Emory Selby First Middle Last				4. DATE OF DEATH February 18, 1957 Month Day Year					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 29, 1891		9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Apartments		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Selby				14. MOTHER'S MAIDEN NAME Christiana Budd					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 579-26- 8743		17. INFORMANT Minerva Washington, Sandy Springs, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D. EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED February 18, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/57		22c. NAME OF CEMETERY OR CREMATORY Ash Memorial		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Swenden</i>				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR FEB 25 1957		24b. REGISTRAR'S SIGNATURE <i>R. H. Sedwick</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John J. [illegible]		Male		45		Feb. 25, 1957	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Boston, Mass.		Boston, Mass.		Coronary artery disease		Natural	
Occupation		Education		Previous Illnesses		Alcohol Consumption	
Teacher		High School		Hypertension		Occasional	
Marital Status		Smoking Habits		Drinking Habits		Last Meal	
Married		Occasional		Occasional		Normal	
Date of Marriage		Date of Last Examination		Date of Last Medical Consultation		Date of Last Hospital Admission	
1945		Feb. 20, 1957		Feb. 20, 1957		Feb. 20, 1957	
Physician's Name		Physician's Address		Physician's Telephone		Physician's Signature	
Dr. [illegible]		[illegible]		[illegible]		[illegible]	
Hospital Name		Hospital Address		Hospital Telephone		Hospital Signature	
[illegible]		[illegible]		[illegible]		[illegible]	
Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's Telephone		Medical Examiner's Signature	
[illegible]		[illegible]		[illegible]		[illegible]	

RECEIVED
FEB 25 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02129

CERTIFICATE OF DEATH

Reg. Dist. No. *44*

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Purcell - Forestville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Purcell - Forestville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <i>5456 Forestville Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>MARGARET L. SHELTON</i>		4. DATE OF DEATH <i>Feb 22 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 2, 1906</i>
9. AGE (In years last birthday) <i>50</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wash. D.C.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>ALBERT SIDNEY REAVIS</i>		14. MOTHER'S MAIDEN NAME <i>ANNIE ALLEN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenos Carcinoma L Kidney</i> <i>180x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>no</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11/19, 1956</i> , to <i>2/22, 1957</i> , that I last saw the deceased alive on <i>2/24, 1957</i> , and that death occurred at <i>10 2 M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. K. Bowie</i>		DATE SIGNED <i>301-BNE</i>	
PHYSICIAN'S NAME (Type) <i>A. K. BOWIE</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-25-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Congressman</i>	22d. LOCATION (City, town, or county) (State) <i>Washington D. C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Kees - Wash. D. C.</i>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BIRTH-DEATH-10
 CERTIFICATE OF DEATH

First Name: *James*
 Last Name: *Thompson*
 Date of Birth: *July 22, 1900*
 Sex: *Male*
 Race: *White*
 Marital Status: *Married*
 Cause of Death: *Heart Disease*

Place of Birth: *Massachusetts*
 Date of Death: *Sept. 2, 1900*
 Age at Death: *20*
 Sex: *Male*
 Race: *White*
 Marital Status: *Married*
 Cause of Death: *Heart Disease*

1. Name of Deceased	James Thompson
2. Date of Birth	July 22, 1900
3. Sex	Male
4. Race	White
5. Marital Status	Married
6. Cause of Death	Heart Disease
7. Place of Birth	Massachusetts
8. Date of Death	Sept. 2, 1900
9. Age at Death	20
10. Sex	Male
11. Race	White
12. Marital Status	Married
13. Cause of Death	Heart Disease

RECEIVED
 FEB 25 1957
 BUREAU V. S.

James Thompson - Mass. B.C.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

2090

1. PLACE OF DEATH o. COUNTY Prince Georges	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	b. COUNTY Pr. Geo.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital	1/d. STREET ADDRESS 5113 Frohlich Lane	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Walter Middle Frank Last Sidders	4. DATE OF DEATH Month Feb. 26, Day 19 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH September 14, 1898	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber	10b. KIND OF BUSINESS OR INDUSTRY New Jersey	11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME William Sidders	14. MOTHER'S MAIDEN NAME Mary Applegate
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. W.W.2	17. INFORMANT Adele Sidders, same address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hyattsville
20f. (City or town) Hyattsville	(County) Pr. Geo.	(State) MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D.	DATE SIGNED February 28, 1957
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/1/57	22c. NAME OF CEMETERY OR CREMATORY Arlington National
22d. LOCATION (City, town or county) Arlington	(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE F. Jacobs	ADDRESS Hyattsville Md	24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the coronator prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02131

Reg. Dist. No. 234

2126

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN lb Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shipman 83X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River near Rosalie Island				d. STREET ADDRESS Route # 1 Pox 68		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James N Simpson				4. DATE OF DEATH Month Day Year February 12 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1926	9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deck hand		10b. KIND OF BUSINESS OR INDUSTRY SMXX Smoot Co.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry H. SMXX Simpson				14. MOTHER'S MAIDEN NAME Leola E. Browning			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW 11		16. SOCIAL SECURITY NO. WW11 225-24-7864		17. INFORMANT Address Alexander M. Browning, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 851X DUE TO Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 219. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from a barge into the river					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 7:30 p.m. 2/12 19 57		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River		20f. (City or town) (County) (State) Oxon Hill P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James T. Boyd				DATE SIGNED February 12, 1957			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF Feb 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Shipman		22d. LOCATION (City, town, or county) (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE 2/15/57	
						24b. REGISTRAR'S SIGNATURE Carrie Campbell	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

15 15 1957

RECEIVED

2127

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince George</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural</u>		<u>16 yrs</u>		TOWN <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6703 Palmer Rd S.E.</u>				STREET ADDRESS (If rural give location) <u>6703 Palmer Rd S.E.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Patience Smallwood</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 7 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>April 26, 1897</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Windsor</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Albert Williams</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Rosel Smallwood - 6703 Palmer</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>				<u>14 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart Failure</u>				<u>24 hrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive Heart Disease</u>				<u>2 yrs.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-25</u> , 19 <u>57</u> , to <u>2-6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-1</u> , 19 <u>57</u> , and that death occurred at <u>4:30 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Anna Coyne Todd</u> M.D. <u>7519 Broadview Rd S.E. D.C. 22</u>				DATE SIGNED <u>2-7-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-13-57</u>		NAME OF CEMETERY OR CREMATORY <u>Church</u>		LOCATION (City, town, or county) (State) <u>OXEN HILL, MD.</u>	
24. REC'D BY REGISTRAR <u>10-11-57</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhines + Co.</u>		ADDRESS <u>901-3rd St. S.W. Wash D.C.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

FEB 11 1957

RECEIVED

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2128

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>5244 O'Dell Road</u>			
3. NAME OF DECEASED (Type or print) <u>Darrell</u> First <u>Smith</u> Middle <u>Smith</u> Last				4. DATE OF DEATH <u>Feb</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-12-57</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.		IF UNDER 24 HRS. Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Samuel Smith</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>7620</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atelectasis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>7 day</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>2/12</u> , 19 <u>57</u> , to <u>2/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/19</u> , 19 <u>57</u> , and that death occurred at <u>5</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>320 Montgomery, Laurel, Md.</u> DATE SIGNED <u>2/20/57</u>							
ACTUAL SIGNATURE <u>Frank L. Weaver, Jr.</u>				PHYSICIAN'S NAME (Type) <u>FRANK L. WEAVER, JR.</u>			
22a. BURIAL-CREATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Queens Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Murkin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u> ADDRESS <u>467 N. St. NW Wash.</u>				24a. REC'D BY REGISTRAR <u>John D. Smith</u> DATE <u>2/23/57</u>			

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077294XV4

CERTIFICATE OF DEATH

Reg. No. 10

1. NAME OF DECEASED [Blank]		2. SEX [Blank]	
3. AGE [Blank]		4. RACE [Blank]	
5. DATE OF BIRTH [Blank]		6. PLACE OF BIRTH [Blank]	
7. DATE OF DEATH [Blank]		8. PLACE OF DEATH [Blank]	
9. CAUSE OF DEATH [Blank]		10. MANNER OF DEATH [Blank]	
11. SIGNATURE OF PHYSICIAN [Blank]		12. SIGNATURE OF REGISTRAR [Blank]	
13. SIGNATURE OF WITNESS [Blank]		14. SIGNATURE OF WITNESS [Blank]	
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97. SIGNATURE OF WITNESS [Blank]		98. SIGNATURE OF WITNESS [Blank]	
99. SIGNATURE OF WITNESS [Blank]		100. SIGNATURE OF WITNESS [Blank]	

RECEIVED
FEB 25 1957
BUREAU V. S.

2129
CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Seat Pleasant	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		d. STREET ADDRESS 6904 - A St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Thomas Smith		4. DATE OF DEATH Month February Day 1st Year 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 24, 1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Smith.		14. MOTHER'S MAIDEN NAME Thresa Trail	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Margaret A. Smith		Address 6904 - A St. wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 411X DUE TO Aortic Stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic heart disease DUE TO (c) 50 yrs INTERVAL BETWEEN ONSET AND DEATH 50 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1954, to 1/31 1957, that I last saw the deceased alive on 1/31 1957, and that death occurred at 4:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John Kehoe M.D. CHEVERLY, MD 2/1/57			
ACTUAL SIGNATURE JOHN KEHOE			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.W. Lee's Sons Co.		ADDRESS 300-4th St. N.	
24a. REC'D BY REGISTRAR DATE 2-4-57		24b. REGISTRAR'S SIGNATURE Carrie F. Campbell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 10

FEB 7 1957

RECEIVED

2091

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, c. LENGTH OF STAY IN 1b 3 Hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier d. STREET ADDRESS 4518 32nd St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John P Sniegoski				4. DATE OF DEATH Month Day Year Feb. 27 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-21-88	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED.				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME FELIX SNIEGOSKI				14. MOTHER'S MAIDEN NAME CECELIA MICHALOWICZ.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. W.W.1		17. INFORMANT Address MRS VIOLA I SNIEGOSKI.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X INTRA-cerebral hemorrhage DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) 5 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 8 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 2/27 , 19 57 , to 2/27 , 19 57 , that I last saw the deceased alive on 2/27 , 19 57 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donat Comeau				ADDRESS (Street, city or town, state) 3503 Penny St		DATE SIGNED 2/27/57	
PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU				MT RAINIER MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery.		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Humphreys & Son				45732 Georgia Ave Washington D.C.		24a. REC'D BY REGISTRAR DATE MAR 5 57	
				24b. REGISTRAR'S SIGNATURE Paul Smith			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. PLACE OF DEATH		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CLERK		16. SIGNATURE OF JUDGE		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF COURT		21. SIGNATURE OF STATE		22. SIGNATURE OF FEDERAL		23. SIGNATURE OF LOCAL		24. SIGNATURE OF OTHER		25. SIGNATURE OF UNKNOWN		26. SIGNATURE OF MISSING		27. SIGNATURE OF DEAD		28. SIGNATURE OF ALIVE		29. SIGNATURE OF SLEEPING		30. SIGNATURE OF WAKING		31. SIGNATURE OF EATING		32. SIGNATURE OF DRINKING		33. SIGNATURE OF SMOKING		34. SIGNATURE OF GAMING		35. SIGNATURE OF LOVING		36. SIGNATURE OF HATING		37. SIGNATURE OF FEARING		38. SIGNATURE OF DREAMING		39. SIGNATURE OF THINKING		40. SIGNATURE OF FEELING		41. SIGNATURE OF MOVING		42. SIGNATURE OF STAYING		43. SIGNATURE OF GOING		44. SIGNATURE OF COMING		45. SIGNATURE OF BEING		46. SIGNATURE OF HAVING		47. SIGNATURE OF DOING		48. SIGNATURE OF SAYING		49. SIGNATURE OF WRITING		50. SIGNATURE OF READING		51. SIGNATURE OF LISTENING		52. SIGNATURE OF TALKING		53. SIGNATURE OF SINGING		54. SIGNATURE OF DANCING		55. SIGNATURE OF PLAYING		56. SIGNATURE OF WORKING		57. SIGNATURE OF LEARNING		58. SIGNATURE OF TEACHING		59. SIGNATURE OF KNOWING		60. SIGNATURE OF UNDERSTANDING		61. SIGNATURE OF REMEMBERING		62. SIGNATURE OF FORGETTING		63. SIGNATURE OF BELIEVING		64. SIGNATURE OF DOUBTING		65. SIGNATURE OF TRUSTING		66. SIGNATURE OF DISTRUSTING		67. SIGNATURE OF HOPEING		68. SIGNATURE OF DESPAIRING		69. SIGNATURE OF LOVING		70. SIGNATURE OF HATING		71. SIGNATURE OF FEARING		72. SIGNATURE OF DREAMING		73. SIGNATURE OF THINKING		74. SIGNATURE OF FEELING		75. SIGNATURE OF MOVING		76. SIGNATURE OF STAYING		77. SIGNATURE OF GOING		78. SIGNATURE OF COMING		79. SIGNATURE OF BEING		80. SIGNATURE OF HAVING		81. SIGNATURE OF DOING		82. SIGNATURE OF SAYING		83. SIGNATURE OF WRITING		84. SIGNATURE OF READING		85. SIGNATURE OF LISTENING		86. SIGNATURE OF TALKING		87. SIGNATURE OF SINGING		88. SIGNATURE OF DANCING		89. SIGNATURE OF PLAYING		90. SIGNATURE OF WORKING		91. SIGNATURE OF LEARNING		92. SIGNATURE OF TEACHING		93. SIGNATURE OF KNOWING		94. SIGNATURE OF UNDERSTANDING		95. SIGNATURE OF REMEMBERING		96. SIGNATURE OF FORGETTING		97. SIGNATURE OF BELIEVING		98. SIGNATURE OF DOUBTING		99. SIGNATURE OF TRUSTING		100. SIGNATURE OF DISTRUSTING	
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BUREAU V. 2

MAR 5 1957

RECEIVED

2092

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13x22 Fulton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy		First Middle Last Speakes		4. DATE OF DEATH Month Day Year Feb 18 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 16 57		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME EDWARD S SPEAKES				14. MOTHER'S MAIDEN NAME ANN MARTIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) NONE		17. INFORMANT Address Ed S. SPEAKES, FULTON MD			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x <u>Respiratory failure</u> DUE TO (b) <u>Premature Birth - 27 weeks</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/14 1957, to 2/17 1957, that I last saw the deceased alive on 2/17 1957, and that death occurred at 3:12 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2/19/57							
ACTUAL SIGNATURE <u>Robert A. McCann</u> M.D.				402 Main St			
PHYSICIAN'S NAME (Type) Samuel J. ...							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-20-57		22c. NAME OF CEMETERY OR CREMATORY GOOD SHEPHERD		22d. LOCATION (City, town, or county) (State) ELLCOTT CITY MD	
23. FUNERAL DIRECTOR'S SIGNATURE E. H. HIGHTHORN				ADDRESS ELLCOTT CITY MD		24a. REC'D BY REGISTRAR DATE FEB 21 57	
				24b. REGISTRAR'S SIGNATURE W. L. ...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF WIFE

NAME OF HUSBAND

NAME OF CHILD

NAME OF CHILD

NAME OF CHILD

NAME OF CHILD

NAME OF CHILD

NAME OF CHILD

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NAME OF CHILD

BUREAU V. 1

FEB 21 1957

RECEIVED

2093
CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 10th St</u>		d. STREET ADDRESS <u>1 206 10th St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lizma</u> Middle <u>Belle</u> Last <u>Stanton</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Marshall Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew J. Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Martha J. Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, no., or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Ann Della Baker</u>		Address <u>206 10th St Laurel Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of thyroid</u> <u>194X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>57</u> , to <u>Feb 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 2</u> , 19 <u>57</u> , and that death occurred at <u>3:12 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert S. McCeney</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>2/2/57</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT S. MCCENEY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/5/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louis Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Honahan</u>		24a. RECEIVED BY REGISTRAR <u>Feb 7-57</u>	
ADDRESS <u>Laurel Md</u>		24b. REGISTRAR'S SIGNATURE <u>M. B. B. B.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for use by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00 3902 Elm Street</u>				d. STREET ADDRESS <u>13902 Elm Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Telghman</u> Last <u>Telghman</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Color.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>Lucas Telghman</u>				14. MOTHER'S MAIDEN NAME <u>Laura Spriggs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Blanche Waters, Upper Marlboro</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 442 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>	
22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Rollins</u>				ADDRESS <u>4339 Hunt Pl., NE</u>		24a. REC'D BY REGISTRAR <u>FEB 27 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. E. Seach</u>							

MEDICAL CERTIFICATION

2

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

James I. Boyd

M.D. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Feb 21, 1957

RECEIVED

FEB 27 1957

BUREAU V. S.

2131

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02139

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Heights</u>				c. LENGTH OF STAY IN 1b <u>21 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2003-53rd Avenue</u>				d. STREET ADDRESS <u>2003-53rd Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>C.</u> Last <u>Trastle</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>upholsterer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>			
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.-C</u>			
13. FATHER'S NAME <u>Joseph Trastle</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Munster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>same as #2</u>			
17. INFORMANT <u>Lula Trastle</u>				Address <u>same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>2/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Suitland, Md.</u>				(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington, D.C.</u>				ADDRESS _____		24a. REC'D BY REGISTRAR <u>Feb 25 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>L. J. Hedrick</u>				DATE _____		24c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

FEB 25 1957

BUREAU V. S.

CERTIFICATE OF DEATH

02140

Reg. Dist. No.

2132

1. PLACE OF DEATH a. COUNTY Prince George's Co.				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Va.				b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Sulphur Springs							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2403- Iverson St. S.E.								d. STREET ADDRESS 85X-3				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GERTIE				First Middle Last M. VANCE				4. DATE OF DEATH Feb. 3rd				Day Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19-1893		9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic				11. BIRTHPLACE (State or foreign country) West Va.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas								14. MOTHER'S MAIDEN NAME Mattie Vance							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Mildred Turner 2403- Iverson St. S.E.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary-arteriosclerotic Heart Disease DUE TO (c) 2 years INTERVAL BETWEEN ONSET AND DEATH 5 min												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 4, 1957, to Feb 3, 1957, that I last saw the deceased alive on Feb 2, 1957, and that death occurred at 12-30A, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1919 North Daniel Street Arlington, Va. Feb. 3-57 ACTUAL SIGNATURE BC Snyder M.D. PHYSICIAN'S NAME (Type) Bertram C. Snyder															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb 6-57				22c. NAME OF CEMETERY OR CREMATORY Hope Cemetery				22d. LOCATION (City, town, or county) (State) R. F. D Cornington Va			
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros - 1661- good Hope				ADDRESS West DC				24a. REC'D BY REGISTRAR DATE FEB 6 1957				24b. REGISTRAR'S SIGNATURE A. H. Zednick			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02141

Reg. Dist. No.

2094

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u> c. LENGTH OF STAY IN 1b <u>16 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>507-61st Avenue</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Capital Heights</u> d. STREET ADDRESS <u>1 507-61st Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Aloysius</u> Last <u>Van Horn</u> 4. DATE OF DEATH Month <u>Feb</u> Day <u>22</u> Year <u>1957</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-26-1910</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>46</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. a</u>	
13. FATHER'S NAME <u>Charles Van Horn</u>				14. MOTHER'S MAIDEN NAME <u>Ella Gladden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-10-9504</u>		17. INFORMANT Address <u>Mrs. Bessie Van Horn, same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> </div> <div style="width: 35%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb 22, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl.</u>		22d. LOCATION (City, town, or county) (State) <u>Switzerland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. 517-11th St. A.E.</u>				24a. REC'D BY REGISTRAR <u>FEB 28 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

FEB 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2095

CERTIFICATE OF DEATH

02142

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lillie</u> First <u>Rebecca</u> Middle <u>Vermillion</u> Last				4. DATE OF DEATH Month <u>Feb</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 Mar 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Ace Tucker</u>				14. MOTHER'S MAIDEN NAME <u>Rachael ----</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>420.1</u>			
17. INFORMANT <u>Louis Vermillion</u> Address <u>6511 C St., Maryland Park, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/2, 1957</u> , to <u>2/2, 1957</u> , that I last saw the deceased alive on <u>2/2, 1957</u> , and that death occurred at <u>1,25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cheverly, Md.</u> DATE SIGNED <u>2/3/57</u>							
ACTUAL SIGNATURE <u>George [Signature]</u> M.D.				PHYSICIAN'S NAME (Type) <u>Cheverly, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Forestville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 6 '57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FEB 6 1957

RECEIVED

2133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN 1b 15 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5013 26th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harriet First Middle Last Wheelock		4. DATE OF DEATH February 11 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1915
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry I. Reavely		14. MOTHER'S MAIDEN NAME Hulda Hendricksen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Arnold Wheelock, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the breast with metastasis to lungs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 11, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Feb 15 57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros 1661 - Good Hope Rd		24a. REC'D BY REGISTRAR DATE FEB 13 57	
		24b. REGISTRAR'S SIGNATURE R. H. H. H.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please re-
 culate the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be
 forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,
 or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—BALTIMORE, 18
Items 11, 13, 14 Film G210 2-14-57 et
2096
CERTIFICATE OF DEATH

02144

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 Mo. 7 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clara Williams		4. DATE OF DEATH Month Day Year Feb. 2 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-10
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Hawkins		14. MOTHER'S MAIDEN NAME Mary Jones Hawkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x Cardiac Insufficiency DUE TO (b) Hypertensive Cardiovascular DUE TO (c) Disease - Chron. Glomerulonephritis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:15 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE George Hawkins M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-57	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Hall Bros. 621 1/2 E. Ave, N.W.		24a. REC'D BY REGISTRAR DATE FEB 5 '57	
		24b. REGISTRAR'S SIGNATURE	

2097

CERTIFICATE OF DEATH

02145

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.		e. STREET ADDRESS 6305-46th. AVE.	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH W. WILLIAMS		4. DATE OF DEATH Month Day Year FEBRUARY 3 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27/1880
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Wyoming, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James ESTELL		14. MOTHER'S MAIDEN NAME Mary Jane Lampton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mary J. Walp, 6305--46th Ave. Riverdale, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 153X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Heart Disease cause (c), stating the underlying cause last. Carcinoma of Cecum & Sigmoid Colon			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-7-57 , to 2-3-57 , that I last saw the deceased alive on 2/3 , 19 57 , and that death occurred at 10:41 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Deitz		ADDRESS (Street, city or town, state) Hagerstown, Md.	
PHYSICIAN'S NAME (Type) A. Deitz		DATE SIGNED 2-3-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/7/1957	
22c. NAME OF CEMETERY OR CREMATORY Dallas Cemetery		22d. LOCATION (City, town, or county) (State) Dallas, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS	
24a. REC'D BY REGISTRAR FEB 6 '57		24b. REGISTRAR'S SIGNATURE Redman	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 6 1957

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2052 CERTIFICATE OF DEATH

Reg. Dist. No.

02146 245

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>7</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2717 Nicholson St.</u>				d. STREET ADDRESS <u>2717 Nicholson St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Williams</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steamfitter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Paris, France</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Vasade</u>				14. MOTHER'S MAIDEN NAME <u>Not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-10-3131A</u>		17. INFORMANT <u>George Williams</u> Address <u>2717 Nicholson St Hyattsville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332 X</u> DUE TO <u>Left Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO (c) <u>10 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260 X Diabetes</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 28</u> , 19 <u>56</u> , to <u>Feb</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 31</u> , 19 <u>57</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>Feb 1, 1957</u> ACTUAL SIGNATURE <u>L. W. Malin</u> M.D. <u>L. W. Malin</u> PHYSICIAN'S NAME (Type) <u>L W Malin</u> <u>Riverdale, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland.</u>				24a. REC'D BY REGISTRAR <u>FEB 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James Sever</u>	

WYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

FEB 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2134

CERTIFICATE OF DEATH

02147

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. #301		d. STREET ADDRESS 1 Rt. #301	
3. NAME OF DECEASED (Type or print) First Robert Middle Lynch Last Wilson		4. DATE OF DEATH Month February Day 11 , Year 19 57.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1910
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Wilson		14. MOTHER'S MAIDEN NAME Nelle Flegal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes.		16. SOCIAL SECURITY NO. W.W. II	
17. INFORMANT Clara King Wilson		Address Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Pericard Disease DUE TO (c) Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH One Hour 6 Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1 , 19 56 , to Feb 11 , 19 57 , that I last saw the deceased alive on Feb 11 , 19 57 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James G. Sasser		ADDRESS (Street, city or town, state) DATE SIGNED Upper Marlboro, Maryland 2/11/57.	
PHYSICIAN'S NAME (Type) James G. Sasser,		M.D. M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/14/57	22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.		ADDRESS Upper Marlboro, Md.	
24a. REC'D BY REGISTRAR DATE FEB 15 '57		24b. REGISTRAR'S SIGNATURE W. H. Smith	

U. S. BUREAU

1957

RECEIVED

2098

CERTIFICATE OF DEATH

Reg. Dist. No. 02148

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		e. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLMAR MANOR</u>		d. STREET ADDRESS <u>3312 - 40th Place</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ross</u> Middle <u>L</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-86</u>		9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist Retired U.S. NAVY yard</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander H Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Jane Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <u>Carne E Wilson</u> Address <u>5312 40th Place Colmar Manor Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.U.A.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-19-57</u> <u>1-11-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hyper-tensive Cardio-renal disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCOUNT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-15</u> , 19 <u>57</u> , to <u>2/23</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>2/23</u> , 19 <u>57</u> ; and that death occurred at <u>9:57</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3277-38th Ave</u> DATE SIGNED <u>2-23-57</u>							
ACTUAL SIGNATURE <u>George J. Haggard</u> M.D.							
PHYSICIAN'S NAME (Type) <u>George J. Haggard</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u>				ADDRESS <u>4812 Calver Ave Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 1 57</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>William V. S.</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>March 1, 1957</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

MAR 1 1957

RECEIVED

2135

CERTIFICATE OF DEATH

Reg. Dist. No.

02149

1. PLACE OF DEATH a. COUNTY Pr. Geo's Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Suitland, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4438- Ewing Ave., S.E.				d. STREET ADDRESS 1451 White Hall St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MARIAN V. WYNN				4. DATE OF DEATH Month Feb. Day 20th Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 8- 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Joseph Dudley				14. MOTHER'S MAIDEN NAME Agnes Hagan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Louise Buchanan -4438- Ewing Ave., S.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 2 MONTHS						INTERVAL BETWEEN ONSET AND DEATH 1 HOUR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While o. m. Not while o. m. <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Suitland, Maryland.				(County) (State)			
21. I certify that I attended the deceased from SEPT. 4, 1956 , to FEB. 20, 1957 , that I last saw the deceased alive on FEB. 12, 1957 , and that death occurred at 7:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7200 MARLBORO RD. DATE SIGNED Feb. 20, 1957							
ACTUAL SIGNATURE John O. Ford				M.D. DISTRICT HEIGHTS, MD.			
PHYSICIAN'S NAME (Type) JOHN O. FORD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers				ADDRESS 1661- Good Hope Road SE Washington, D.C.		24a. REC'D BY REGISTRAR FEB 21 1957	
				24b. REGISTRAR'S SIGNATURE Carrie Compbell			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1912	
Place of Birth		Married		Occupation		Cause of Death	
Baltimore, Md.		Yes		Teacher		Heart Disease	
Residence		Domicile		Hospital		Physician	
123 Main St.		123 Main St.		St. Mary's		Dr. Smith	
Date of Death		Time of Death		Place of Death		Burial Place	
Feb 15, 1957		10:30 AM		St. Mary's		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 8

FEB 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02150

Reg. Dist. No.

2135

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale			c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2204 Queens Chapel Road				d. STREET ADDRESS 2204 Queens Chapel Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Jen Young				4. DATE OF DEATH Month Day Year February 24 1957				
5. SEX Female		6. COLOR OR RACE Chinese		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 20, 1929		
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher			10b. KIND OF BUSINESS OR INDUSTRY University		11. BIRTHPLACE (State or foreign country) China		12. CITIZEN OF WHAT COUNTRY? China ✓	
13. FATHER'S NAME Chia Heng				14. MOTHER'S MAIDEN NAME Lu Jen				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Husband: same address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hanging DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging by the neck from a water pipe, using a portion of sheet.						
20c. TIME OF INJURY Month, Day, Year Hour: 2-24-57		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Avondale, Pr. Geo. Maryland		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED February 24, 1957				
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2/27/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR FEB 28 '57		24b. REGISTRAR'S SIGNATURE <i>Deborah</i>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [REDACTED]
 SEX: [REDACTED]
 AGE: [REDACTED]
 DATE OF BIRTH: [REDACTED]
 PLACE OF BIRTH: [REDACTED]
 OCCUPATION: [REDACTED]
 CAUSE OF DEATH: [REDACTED]
 MANNER OF DEATH: [REDACTED]
 SIGNATURE OF EXAMINER: [REDACTED]
 DATE: [REDACTED]

REPORTED BY: [REDACTED]
 RELATIONSHIP: [REDACTED]
 ADDRESS: [REDACTED]
 CITY: [REDACTED]
 STATE: [REDACTED]
 ZIP: [REDACTED]

BUREAU A. S.

FEB 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02151

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trump's Hill		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Trump's Hill Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X / Trump's Hill	
3. NAME OF DECEASED (Type or print) First Middle Last James Young		4. DATE OF DEATH Month Day Year February 9 19 57	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 5, 1891	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Young		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Jesse Townsend	
17. INFORMANT Jesse Townsend		Address Same as # 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11-57	
22c. NAME OF CEMETERY OR CREMATORY Lafayette Med. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James I. Boyd		24a. REC'D BY REGISTRAR DATE FEB 13 '57	
24b. REGISTRAR'S SIGNATURE W. J. Smith		DATE SIGNED February 9, 1957	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

1957

RECEIVED

2138 CERTIFICATE OF DEATH

Reg. Dist. No.

02152

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u> <u>X2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence</u>		d. STREET ADDRESS <u>1518 59th Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FRANK</u> First <u>HENRY</u> Middle <u>ZELL</u> Last		4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>X</u> <u>X</u> <u>X</u>	8. DATE OF BIRTH <u>May 8, 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Star Newspaper</u>	
11. BIRTHPLACE (State or foreign country) <u>Alexandria, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver Zell</u>		14. MOTHER'S MAIDEN NAME <u>Ada Clapdoor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>578-10-2484</u>	
17. INFORMANT <u>Mrs. Maidie Zell</u>		Address <u>1518 59th Ave., Hillside Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>MYOCARDIAL INSUFFICIENCY</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/12</u> , 19 <u>57</u> , to <u>PRESENT</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/22/</u> 19 <u>57</u> , and that death occurred at <u>4:58</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4400 Bowen Road, S.E., Washington D.C.</u> DATE SIGNED ACTUAL SIGNATURE <u>Thomas F. Cullen M.D.</u> M.D. <u>4400 Bowen Road, S.E., Wash., D.C.</u> PHYSICIAN'S NAME (Type) <u>THOMAS F. CULLEN, M.D.</u> <u>4400 Bowen Road, S.E., Wash., D.C.</u>			
22a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL <input type="checkbox"/>	22b. DATE THEREOF <u>Feb. 26, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO., 517 11th St., S.E.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	24b. REGISTRAR'S SIGNATURE <u>Ans. Louch</u>

FEB 28 '57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 28 1957

RECEIVED